MILITARY CONSTRUCTION, VETERANS AFFAIRS, AND RELATED AGENCIES APPROPRIATIONS FOR 2014

THURSDAY, APRIL 18, 2013.

DEPARTMENT OF VETERANS AFFAIRS BUDGET

WITNESS

HON. ERIC K. SHINSEKI, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

CHAIRMAN OPENING STATEMENT

Mr. CULBERSON. Good morning. The Subcommittee on Military Construction and Veterans Affairs will come to order. We delighted to have with us the Secretary of Veterans Affairs, and we have got a lot of questions for you and a vote coming up in about an hour, and I know the members of the committee all have questions for you, Mr. Secretary. And we are delighted to have you here and appreciate your service to the country. As each and every one, we are grateful to your service to the Nation and our men and women who have served our country so faithfully. And I would like at this time to introduce my friend Mr. Bishop for any statement he would like to make.

RANKING MEMBER OPENING STAETMENT

Mr. BISHOP. Thank you very much, Mr. Chairman.

Mr. Chairman, we have done a lot to ease the burden of military service. For example, Congress passed the 9/11 GI bill, the Hiring Heroes Act, and the Caregivers Act all with very strong bipartisan majorities. However, we are still struggling in one area that can make a world of difference to a veteran, and this is the area of the claims process.

We have a serious problem in the country when there are over 850,000 veterans waiting compensation claims and over 600,000 that have waited in excess of 125 days, commonly referred to as backlogged. I have heard from many on the reasons for the backlog, and the inclusion of the Agent Orange, the winding down of the wars in Iraq and Afghanistan, the complexity of the new wounds, both physical and mental, to our veterans and others, but what I want to hear today and what I would like to discuss is what is actually being done to fix it.

I want to talk about results and how this fiscal year 2014 budget is going to achieve those results. How are the initiatives and funding in this budget going to meet the Department's goal to end the

backlog by 2015? Because we can talk about increases in spending for VA until we are blue in the face, but if there are no results, then we are just wasting time and resources.

Mr. Chairman, when it comes to wasting resources in this current budget climate, I can't tell you how frustrated and how disappointed I am and many Members are in the recent announcement on the integrated electronic health record program. Less than a year ago, Mr. Secretary, you and Secretary Panetta appeared before Congress, promising to develop a single common joint electronic health record that would, according to your statement then, unify the two Departments' electronic health record systems into a common system to ensure that all DOD and VA health facilities have service members' and veterans' health information available throughout their lifetimes.

I am aware of the statement that was issued within the last 48 hours by Secretary Hagel, but I personally believe that DOD probably shoulders much more of the blame in this area than the VA, and also much more of the wasted cost; but nonetheless, I am very, very weary of the promises made to the Members of this Congress on behalf of veterans with no results.

So, Mr. Secretary, when I talk to veterans, their number one issue is always VA claims, and the number one issue being worked by my staff in our district offices is VA claims. The veterans in my district are growing impatient, and so am I.

So, Mr. Chairman, today is a very important hearing, and I know I speak for many of our colleagues and for Secretary Shinseki when I discuss how frustrated we all are with the situation. I know this is a problem that won't be fixed overnight, but my hope today is that we can focus on how we fix this problem together and how we fix it quickly, not just for the veterans waiting today, but for future generations of veterans to come.

Mr. Chairman, thank you for the opportunity to share my concerns, and I yield back.

Mr. CULBERSON. Thank you, Mr. Bishop.

I share those sentiments with Mr. Bishop. It is just truly unacceptable the length of time it has taken to handle the disability claims process, and the absence of a unified electronic medical record is something that has absolutely got to be solved immediately.

Now it is my pleasure to introduce and recognize the distinguished chairman of the full committee, the gentleman from Kentucky, Mr. Rogers.

FULL COMMITTEE CHAIRMAN OPENING STATEMENT

Mr. ROGERS. Thank you, Chairman Culberson, for yielding me this time. Secretary Shinseki and your staff, thank you for being with us today to discuss your 2014 budget. And I have already lamented the fact that this budget is woefully late, and in its totality it has got a lot of gimmicks, tax increases, generally unhelpful, but we will persevere.

Let me begin by taking this opportunity to thank the service and sacrifice of the veterans that you are representing here today. As this subcommittee has done in the past, we want to reaffirm our commitment to providing our Nation's veterans with the benefits

they deserve. The Department of Veterans Affairs budget we will be discussing in detail today provides the funding for VA, medical care compensation benefits, as well as education benefits, vocational rehab and housing loan programs. We have the responsibility to ensure that after serving our Nation with dignity and honor, our Nation's veterans receive the best care available.

Along with other members of the subcommittee, I share the concern about the backlog of disability claims. While there has been an unprecedented demand after 10 years of war, changes to PTSD and Agent Orange eligibility and other revisions resulting in 940,000 veterans added to the system over the last 4 years, it is woefully unacceptable that 70 percent of these pending claims are over 125 days old. That is especially disconcerting as this subcommittee has gone to great lengths to make additional investments in processing and efficiency. I am, however, encouraged to hear about recent contract awards to speed electronic document conversion, and am hopeful that you can quickly build on these steps to significantly reduce, if not end, the backlog by 2015.

You may recall that last year I and other members of the subcommittee emphasized to you how important we feel it is for the VA and the Defense Department to create an integrated electronic health record. We were encouraged by the progress both Departments seemed to be making on that effort, but I understand now that you and DOD have opted to create two separate record systems that would be interoperable. We hope that you will be able to convince us that this revised approach will produce the same result without delays and without increased costs.

Finally, as you and I have briefly chatted before the meeting, prescription drug abuse, the Nation's fastest-growing drug problem, remains one of my top priorities. The Centers for Disease Control calls it a national epidemic. It is killing more people than car wrecks, just simply prescription drug overuse and abuse. In the past several years, we have had many discussions on how we can better help our veterans prevent prescription drug abuse or offer assistance to those facing addiction, and I look forward to continuing to work with you as we tackle this epidemic.

And I know our active duty military and our veterans are sort of in a different posture in relation to this problem because of the multiple moves they have had to make in their career in different theatres, in different hospitals and medical care around the world, and I know that presents extra challenges for you, but this is a deadly problem that I know that you are working on, and I appreciate that.

I yield back, Mr. Chairman.

Mr. CULBERSON. Thank you, Mr. Chairman.

It is my privilege to recognize the distinguished ranking member Mrs. Lowey from New York.

FULL COMMITTEE RANKING MEMBER OPENING STATEMENT

Mrs. LOWEY. And I thank you, Mr. Chairman. And I would like to thank you and Ranking Member Bishop for holding this important hearing, and welcome Secretary Shinseki and all of our distinguished guests this morning.

As the subcommittee works on the fiscal year 2014 bill, we have to help the Department of Veterans Affairs address very serious challenges. We must ensure that the men and women who have faithfully served our Nation receive the recognition and benefits they earned. We can never renege on the promises made to our veterans.

Mr. Secretary, I commend you on the excellent work you have done in the past 4 years to substantially reduce veteran homelessness. I am also pleased with your progress to help facilitate a smoother transition from active duty to civilian life, but as you have heard from my colleagues on both sides of the aisle, I cannot express how outraged I am with the veterans claims backlog. As you know, there are currently up to 600,000 veterans waiting 125 days or more to have their medical claims processed. The VA's annual claims receipts are expected to reach 1.2 million in 2013, an increase of almost 60 percent since 2005.

On Tuesday, I asked Secretary Hagel about the Department of Defense's role in the claims backlog. Both Departments, in my judgment—and I didn't know it was resolved, Mr. Chairman, but in my judgment, after hearing a lot of testimony and talking to many people, it seems to me they must use either the same electronic health record system, which is preferable, or ones that work seamlessly with each other.

I asked Secretary Hagel how he plans to help the VA to reduce this backlog, because, frankly, there are many people with whom I have spoken that put the blame on the Department of Defense for not getting their act together and working seamlessly with your system. He told me, Secretary Hagel, that DOD would decide on an electronic medical records plan within 30 days. So I look forward to hearing about that.

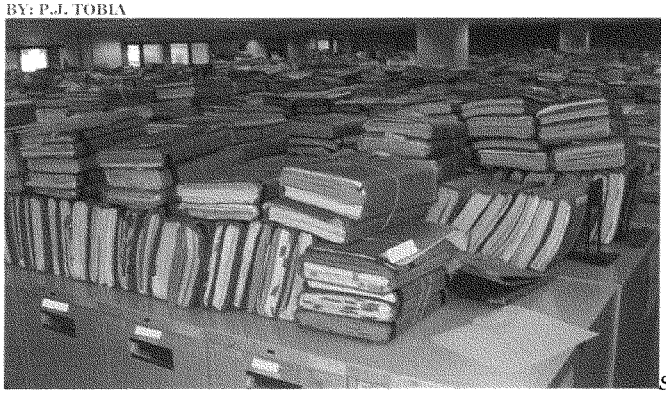
I just want to submit these pictures to include in the record. I probably should have blown them up, but I can't believe it, boxes and boxes of records. I don't know if you have seen them, Mr. Secretary. These are claim folders in Winston-Salem, North Carolina. I would like to ask you all later when I ask a question if you have taken a look at that, and if you have, how do you sleep at night? Boxes and boxes of records in Winston, North Carolina. If you would like to see them, I will pass these on to you, but I am submitting them for to the record.

Mr. CULBERSON. They will be entered in the record.

[The information follows:]

Veterans Affairs Backlog Files Stacked So High, They Posed Safety Risk to Staff

BY: P.J. TOBIA



Stacks of Veterans Affairs claim folders overtake a regional office in Winston-Salem, N.C. These photos were included in a 2012 report from the Veterans Affairs Office of Inspector General.

While researching **our story** on the Veterans Affairs benefits backlog, we saw **this Veterans Affairs Administration Inspector General's report** that points out that at one VA center, a regional office in Winston-Salem, N.C., had so much paper that it "created an unsafe workspace for (VA) employees and appeared to have the potential to compromise the integrity of the building." The IG report, from August, 2012, found that at this one office alone, "37,000 claims folders were stored on top of file cabinets." The report says that this "creates an unsafe environment for the employees, overexposes many claims folders to risk of fire/water damage, inadvertent loss and possible misplacement, as well as impedes (Veterans Affairs Regional Office) productivity by reducing access to many folders in a timely manner."

According to the report, the sheer weight of the combined folders actually exceeded the load-bearing capacity of the building itself.

As claims continue to pour in, almost one million veterans are currently waiting for their benefit claims to be processed, according to an**investigation conducted by the Center for Investigative Reporting**. The CIR's report also showed that the average wait time for a disability claim to be resolved is 279 days. First time claims take longer, averaging 318 days, and the wait time has grown 2,000 percent in the past four years.

Mrs. LOWEY. It is really amazing to me that these paper files exist, and these brave young men and women who are serving our country, many come back without limbs, have their records to sit in a box.

Now, I know everyone here, everyone in this room, you have heard from all my colleagues, wants to fix this shameful problem, yet it persists. I just hope at this point we can all work together to address this pressing issue. And I look forward to hearing your testimony, Mr. Secretary. I thank you again for your service to your country, and I do hope that the new Secretary of Defense works with you and gets this done, because the public just can't get it. You know, if we can go to war, and we have an extraordinary military, and we can't solve this problem and get these records out of the boxes, that is just wrong. So, enough.

Thank you very much, Mr. Chairman.

Mr. CULBERSON. Thank you very much, Mrs. Lowey.

Mr. Secretary, I know that you and your staff can see clearly that we are, all of us on this subcommittee and the Congress, arm in arm in complete agreement that the backlog is unacceptable; that we have, as a Congress—you know that we have made massive investments in Veterans Administration, exempted you from the sequestration. You have seen a 16 percent increase in funding for your budget in the mandatory programs; tremendous support from the Congress and unanimous, adamant feelings on our part that this has to change. The backlog has to change, and the electronic medical records need to be unified. We know you have done your part as best you can on the medical records.

But we look forward to your testimony. We encourage you to summarize it, we have got votes at about 11:30, and help us focus on the problems that we can help you solve. We want to hear, obviously, about the successes, but talk to us about the problems. We appreciate very much your service to the country and look forward to your testimony, and your entire statement will be entered into the record, and we look forward to hearing from you, sir. Thank you.

SECRETARY'S STATEMENT

Secretary SHINSEKI. Thank you.

Chairman Culberson, Ranking Member Bishop, Chairman Rogers, Ranking Member Lowey, other distinguished members of the committee, thank you for this opportunity to present the President's 2014 and 2015 advance appropriations requests for VA. We deeply value your partnership and support in providing the resources needed to assure the quality of care and services we provide to veterans.

Let me also acknowledge other partners who are in the room today, some of our veteran service organizations, whose insights and support make us much better at our mission of caring for veterans, their families and our survivors.

Mr. Chairman, I would just like to take a minute to introduce others who are here at the witness table with me. To my left, far left, your right, is Mr. Stephen Warren, our Acting Assistant Secretary for Information and Technology. To my left is Todd Grams, our Chief Financial Officer. To my right is Dr. Randy Petzel, Under

Secretary for Health. To his right, Allison Hickey, Under Secretary for Benefits. And then to the far right, Steve Muro, who is Under Secretary for Memorial Affairs.

Mr. Chairman, thank you for accepting my written statement for the record. Let me just say very quickly. The 2014 budget and 2015 advance appropriations requests demonstrate the President's steadfast commitment to our Nation's veterans and you all as well. I thank the Members for your resolute commitment to our veterans as well, for the budgets that we have worked together, and I seek your support on these requests.

The latest generation of veterans is enrolling in VA at a higher rate than previous generations. Sixty-two percent of those who deployed in support of operations in Afghanistan and Iraq have used at least one VA benefit or service. VA's requirements are expected to continue growing for years to come. Our plans and resources must be robust enough to care for them all.

The President's 2014 budget for VA requests $152.7 billion; $66.5 billion in discretionary funding and $86.1 billion in mandatory funding, an increase of $2.7 billion in the discretionary account, about 4.3 percent above the 2013 level.

Mr. Chairman, this is a strong budget, which enables us to continue building momentum for delivering on three promises we made nearly 4 years ago now. The first was to increase veterans' access to VA's benefits and services.

The second was to go after the disability claims backlog, something that has been building for decades. We committed to ending it in 2015, and we put together a robust plan. We are in execution of it, still targeted on 2015.

And the third promise was to end veterans' homelessness in this country, this rich and powerful country, and we targeted 2015 for accomplishing that.

These were bold and ambitious goals then. They remain bold and ambitious goals today, because veterans deserve a VA that advocates for them and then goes and fights and puts resources behind its promises.

Access. Of the roughly 22 million living veterans in the country today, more than 11 million now receive at least one VA benefit or service from VA, an increase of over a million veterans in the last 4 years. We have achieved this by opening new facilities, renovating others; increasing investments in telehealth and telemedicine; sending mobile clinics and vet centers to remote areas where veterans live; and using every means available, including social media, to connect more veterans to VA. Increasing access is a success story for VA.

Backlog. I hear the comments of the members of this committee. Too many veterans wait too long to receive benefits they deserve. There is no question about that. We know this is unacceptable, it is unacceptable to me, and no one wants to turn this situation around more than this Secretary, more than Secretary Hickey, or more than the workers of VBA, 52 percent of whom are veterans themselves. They have an interest in this. We are resolved to eliminate the claims backlog in 2015, not just reduce it, end it, when claims will be processed at 125 days or less—that is our 2015 measure of success—at a 98 percent accuracy level.

Our efforts mandate investments in VBA's people, processes and technology. And so very quickly, people. More than 2,300 claims processes have completed training to improve the quality and productivity of claims decisions. More are being trained, and VBA's new employees now complete more claims per day than their predecessors.

Processes. Use of disability benefits questionnaires, or what we call DBQs, are online forms for submitting medical evidence, that have dropped average processing times of medical claims and improved accuracy. There are now three lanes for processing claims: An express lane for those that will predictably take less time; a special operations lane, for the unusual cases or those requiring special handling; and then a core lane for the remainder, which are the majority of claims.

Now, technology is critical to this process as well; people, process and technology. Technology is critical to ending the backlog. Our paperless processing system, the Veterans Benefits Management System, VBMS, will be faster, improve access, drive automation, and reduce variance. Thirty-six regional offices today are using VBMS. We are targeted to complete the fielding of VBMS by the end of this year. All 56 will have it, and we are pulling that fielding plan as far to the left as we can.

Finally, homelessness. The last of our three priority goals has been to end veteran homelessness in 2015. Since 2009, we have reduced the estimated number of homeless veterans by more than 17 percent. The latest available estimate from January 2012 is 62,600. There is more work to be done here, but we have mobilized a national program that reaches into communities all across the country. Prevention of veterans' homelessness will be the follow-on main effort. Right now it is rescue and getting people off the streets. It must be accompanied with a prevention program that keeps more veterans from ending up there.

So, finally, Mr. Chairman, we are committed to the responsible use of the resources provided by the Congress. Again, thank you for this opportunity to appear here today. I regret the lateness of the submission of our budget, but I thank you for your support of veterans and of our request.

Mr. CULBERSON. Thank you, Mr. Secretary.

[The information follows:]

Department of Veterans Affairs

Washington, D.C.

The Honorable Eric K. Shinseki

Secretary of Veterans Affairs

Retired U.S. Army General Eric K. Shinseki was nominated by President Barack Obama on Dec. 7, 2008 to serve as Secretary for the United States Department of Veterans Affairs. His nomination was confirmed by the Senate January 20, 2009, and he was sworn in as the seventh Secretary of Veterans Affairs on January 21, 2009.

General Shinseki served as Chief of Staff, United States Army, from 1999 until June 11, 2003, and retired from active duty on August 1, 2003. During his tenure, he initiated the Army Transformation Campaign to address both the emerging strategic challenges of the early 21st century and the need for cultural and technological change in the United States Army.

Following the Sept. 11, 2001 terrorist attacks, he led the Army during Operations Enduring Freedom and Iraqi Freedom and integrated the pursuit of the Global War on Terrorism with Army Transformation, enabling the Army to continue to transform while at war.

Prior to becoming the Army's Chief of Staff, General Shinseki served as the Vice Chief of Staff from 1998 to 1999, after serving simultaneously as Commanding General, United States Army, Europe and Seventh Army; Commanding General, NATO Land Forces, Central Europe, both headquartered in Heidelberg, Germany; and Commander of the NATO-led Stabilization Force, Bosnia-Herzegovina, headquartered in Sarajevo.

He was commissioned a second lieutenant of Artillery upon graduation from the United States Military Academy in June 1965, and was attached to Company A, 1st Battalion, 14th Infantry Regiment, 25th Infantry Division as a forward observer from December 1965 to September 1966, when he was wounded in combat in the Republic of Vietnam. He was returned to Tripler Army Medical Center, Honolulu, Hawaii to recuperate, following which he was assigned as Assistant Secretary, then Secretary to the General Staff, U.S. Army, Hawaii, Schofield Barracks, from 1967-1968. He transferred to Armor Branch and attended the Armor Officer Advanced Course at Fort Knox, Ky, before returning to Vietnam a second time in 1969. While serving as Commander, Troop A, 3d Squadron, 5th Cavalry Regiment, he was wounded in action a second time in 1970.

Other assignments include Commander, 3rd Squadron, 7th Cavalry, 3rd Infantry Division; Commander, 2nd Brigade, 3rd Infantry Division; Deputy Chief of Staff, Support for Allied Land Forces Southern Europe; Assistant Division Commander-Maneuver, 3rd Infantry Division; Commander, 1st Cavalry Division, as well as G-3, 3rd Infantry Division, 1984-1985; G-3, VII US Corps, 1989-1990; and Deputy Chief of Staff for Operations and Plans, Headquarters, Department of the Army, 1996-1997.

Shinseki holds a Bachelor of Science degree from the U.S. Military Academy at West Point; a Master of Arts degree from Duke University, and is a graduate of the National War College. General Shinseki has been awarded the Defense Distinguished Service Medal, Distinguished Service Medal, Legion of Merit (with Oak Leaf Clusters), Bronze Star Medal with "V" Device (with 2 Oak Leaf Clusters), Purple Heart (with Oak Leaf Cluster), Defense Meritorious Service Medal, Meritorious Service Medal (with 2 Oak Leaf Clusters), Air Medal, Parachutist Badge, Ranger Tab, Joint Chiefs of Staff Identification Badge, and the Army Staff Identification Badge.

January 2009

STATEMENT OF THE HONORABLE ERIC K. SHINSEKI
SECRETARY OF VETERANS AFFAIRS

FOR PRESENTATION BEFORE THE
HOUSE APPROPRIATIONS COMMITTEE, SUBCOMMITTEE ON MILITARY CONSTRUCTION, VETERANS AFFAIRS AND RELATED AGENCIES

BUDGET REQUEST FOR FISCAL YEAR 2014

APRIL 18, 2013

Chairman Culberson, Ranking Member Bishop, Distinguished Members of the House Appropriations Committee, Subcommittee on Military Construction, Veterans Affairs and Related Agencies:

Thank you for the opportunity to present the President's 2014 Budget and 2015 advance appropriations requests for the Department of Veterans Affairs (VA). This budget continues the President's historic initiatives and strong budgetary support and will have a positive impact on the lives of Veterans, their families, and survivors. We value the unwavering support of the Congress in providing the resources and legislative authorities needed to care for our Veterans and recognize the sacrifices they have made for our Nation.

The current generation of Veterans will help to grow our middle class and provide a return on the country's investments in them. The President believes in Veterans and their families, believes in providing them the care and benefits they've earned, and knows that by their service, they and their families add strength to our Nation.

Twenty-two million living Americans today have distinguished themselves by their service in uniform. After a decade of war, many Servicemembers are returning and making the transition to Veterans status. The President's 2014 Budget for VA requests $152.7 billion – comprised of $66.5 billion in discretionary funds, including medical care collections, and $86.1 billion in mandatory funds. The discretionary request reflects an increase of $2.7 billion, 4.3 percent above the 2013 level. Our 2014 budget will allow VA to operate the largest integrated healthcare system in the country, with more than 9.0 million Veterans enrolled to receive healthcare; the ninth largest life insurance provider, covering both active duty members as well as enrolled Veterans; an education assistance program serving over 1 million students; a home mortgage service that guarantees over 1.5 million Veterans' home loans with the lowest foreclosure rate in the Nation; and the largest national cemetery system that leads the Nation as a high-performing organization, with projections to inter about 121,000 Veterans and family members in 2014.

Priority Goals

Over the next few years, more than one million Veterans will leave military service and transition to civilian life. VA must be ready to care for them and their families. Our data shows that the newest of our country's Veterans are relying on VA at unprecedented levels. Through January 31, 2012, of the approximately 1.58 million Veterans who returned from Operations Enduring Freedom, Iraqi Freedom, and New Dawn, at least 62 percent have used some VA benefit or service.

VA's top three priorities – increase access to VA benefits and services; eliminate the disability compensation claims backlog in in 2015; and end Veterans homelessness, also in 2015 – anticipate these changes and identify the performance levels required to meet emerging needs. These ambitious goals will take steady focus and determination to see them through. As we enter the critical funding year for VA's priority goals, this 2014 budget builds upon our multi-year effort to position the Department through effective, efficient, and accountable programming and budget execution for delivering claims and homeless priority goals.

Stewardship of Resources

Safeguarding the resources – people, money, time – entrusted to us by the Congress, managing them effectively, and deploying them judiciously, is a fundamental duty. Effective stewardship requires an unflagging commitment to use resources efficiently with clear accounting rules and procedures, to safeguard, train, motivate, and hold our workforce accountable, and to assure the effective use of time in serving Veterans on behalf of the American people. Striving for excellence in stewardship of resources is a daily priority. At VA, we are ever attentive to areas in which we need to improve our operations, and are committed to taking swift corrective action to eliminate any financial management practice that does not deliver value for Veterans.

VA's stewardship of resources begins at headquarters. Recognizing the very difficult fiscal constraints facing our country, the 2014 request includes a 5.0 percent reduction in the Departmental Administration budget from the 2013 enacted level. This reduction follows a headquarters freeze in the 2013 President's Budget — a two-year commitment.

Recent audits of the Department's financial statements have certified VA's success in remediating all three of our remaining material weaknesses in financial management, which had been carried forward for over a decade. In terms of internal controls and fiscal integrity, this was a major accomplishment. In the past four years, we have also dramatically reduced the number of significant financial deficiencies from 16 to 1.

At VA, we believe that part of being responsible stewards is shutting down information technology (IT) projects that are no longer performing. Developed by our

Office of Information and Technology, the Project Management Accountability System (PMAS) requires IT projects to establish milestones to deliver new functionality to its customers every 6 months. Now entering its third year, PMAS continues to instill accountability and discipline in our IT organization. Through PMAS, the cumulative, on-time delivery of IT functionality since its inception is 82 percent, a rate unheard of in the industry where, by contrast, the average is 42 percent. By implementing PMAS, we have achieved at least $200 million in cost avoidance by shutting down or improving the management of 15 projects.

Through the effective management of our acquisition resources, VA has achieved savings of over $200 million by participating in Federal strategic sourcing programs and establishing innovative IT acquisition contracts. In 2012, VA led the civilian agencies in contracting with Service-Disabled Veteran-Owned Small Businesses, which, at $3.4 billion, accounted for 19.3 percent of all VA procurement awards. In addition, we have reduced interest penalties for late payments by 19 percent (from $47 to $38 per million) over the past four years.

Finally, VA's stewardship achieved savings in several other areas across the Department. The National Cemetery Administration (NCA) assumed responsibility in 2009 for processing First Notices of Death to terminate compensation benefits to deceased Veterans. Since taking on this responsibility, NCA has advised families of the burial benefits available to them, assisted in averting overpayments of some $142 million in benefit payments and, thereby, helped survivors avoid possible collections. In addition, we implemented the use of Medicare pricing methodologies at the Veterans Health Administration (VHA) to pay for fee-basis services, resulting in savings of over $528 million since 2012 without negatively impacting Veteran care and with improved consistency in billing and payment.

Technology

To serve Veterans as well as they have served us, we are working on delivering a 21st century VA that provides medical care, benefits, and services through a digital infrastructure. Technology is integrated with everything we do for Veterans. Our hospitals use information technology to properly and accurately distribute and deliver prescriptions/medications to patients, track lab tests, process MRI and X-ray imaging, coordinate consults, and store medical records. VA IT systems supported over 1,300 VA points of healthcare in 2012: 152 medical centers, 107 domiciliary rehabilitation treatment programs, 821 community-based outpatient clinics, 300 Vet Centers, 6 independent outpatient clinics, 11 mobile outpatient clinics, and 70 mobile Vet Centers. Technology supports Veterans' education and disability claims processing, claims payments, home loans, insurance, and memorial services. Our IT infrastructure consists of telephone lines, data networks, servers, workstations, printers, cell phones, and mobile applications.

No Veteran should have to wait months or years for the benefits that they have earned. We will eliminate the disability claims backlog in 2015; technology is the critical component for achieving our goal. VA is deploying technology solutions to improve access, drive automation, reduce variance, and enable faster and more efficient operations. Building on the resources Congress has provided in recent years to expand our claims processing capacity, the 2014 budget requests $291 million for technology to eliminate the claims backlog— $155 million in Veterans Benefits management System (VBMS) for our new paperless processing system, and $136 million in the Veterans Benefits Administration (VBA) to support a Veterans Claims Intake Program, our new online application system that will allow for the conversion of paper to digital images for our new paperless processing system, the Veterans Benefits Management System (VBMS). Without these resources, VA will be unable to meet its goal to eliminate the disability claims backlog in 2015.

Information Technology

At VA, advances in technology -- and the adoption of and reliance on IT in our daily commercial life -- have been dramatic. Technology is integral to providing high quality healthcare and benefits. The 2014 budget requests $3.683 billion for IT, an increase of $359 million from the President's 2013 Budget, reflecting the critical role technology plays in VA's daily work in serving and caring for Veterans and their families. Of the total request, $2.2 billion will support the operation and maintenance of our digital infrastructure and $495 million is for IT development modernization and enhancement projects.

The 2014 budget includes $32.8 million for development of VBMS, our new paperless processing system that enables VA to move from its current paper-based process to a digital operating environment that improves access, drives automation, reduces variance, and enables faster, more efficient operations. As we increase claims examiners' use of VBMS version 4.2 to process rating disability claims, our major focus is on system performance, as we tune the system to be responsive and effective. VA will complete the rollout of VBMS in June 2013.

In addition, the 2014 budget includes $120 million for development of the Veterans Relationship Management (VRM) initiative, which enhances Veterans' access to comprehensive VA services and benefits, especially in the delivery of compensation and pension claims processing. The program gives Veterans secure, personalized access to benefits and information and allows a timely response to their inquiries. Recently, VRM released Veterans Online Application Direct Connect (VDC), which enables Veterans to apply for VBA benefits by answering guided interview questions through the security of the eBenefits portal. Claims filed through eBenefits use VDC to load information and data directly into VBMS.

The Virtual Lifetime Electronic Record (VLER) is an overarching program which aims to share health, benefits, and administrative information, including personnel records and military history records, among DoD, VA, SSA, private healthcare providers, and other

Federal, State and local government partners. eBenefits is already reaching 2 million Veterans and Servicemembers and 1 million active users with BlueButton. The 2014 budget requests $15.4 million for VLER to develop and support these functions as well as the Warrior Support Veterans Tracking Application; the Disability Benefits Questionnaires; a VA/DoD joint health information sharing project known as Bidirectional Health Information Exchange; and a storage interface known as Clinical Data Repository/Health Data Repository. All of these efforts are designed to enable the sharing of health, military personnel and personal information among VA, other Federal agencies, Veteran Service Organizations and private health care providers to expedite the award and processing of disability claims and other services such as education, training and job placement.

Eliminating the Claims Backlog

Too many Veterans wait too long to receive benefits they have earned. This is unacceptable. Today's claims backlog is the result of several factors, including: increased demand; over a decade of war with many Veterans returning with more severe, complex injuries; decisions on Agent Orange, Gulf War, and combat PTSD presumptions; and, successful outreach to Veterans informing them of their benefits. These facts, in no way, diminish the urgency that we all feel at VA to fix this problem which has been decades in the making. VA remains focused on eliminating the disability claims backlog in 2015 and processing all claims within 125 days at a 98-percent accuracy level.

To deliver this goal, the Veterans Benefits Administration (VBA) is implementing a comprehensive transformation plan based on more than 40 targeted initiatives to boost productivity by over the next several years However, as VBA transforms its people, processes, and technologies, its claims demand is expected to exceed on million annually. From 2010 through 2012, for the first time in its history, VBA processed more than one million claims in three consecutive years. In 2013, VBA expects to receive another million claims and similar levels of demand are anticipated in 2014. This is driven by successful outreach, claims growth not previously captured in VBA's baseline, and new requirements. Included are mandatory Servicemember participation in VOW/VEI benefits briefings and an expected increase upon successful completion of a transition assistance program, revamped by the President as Transition: Goals, Plan, Success (GPS). As more than one million troops leave service over the next 5 years, we expect our claims workload to continue to rise. In addition, VBA is experiencing an unprecedented workload growth arising from the number and complexity of medical conditions in Veterans' compensation claims. The average number of claimed conditions for our recently separated Servicemembers is now in the 12 to 16 range – roughly 5 times the number of disabilities claimed by Veterans of earlier eras. While the increase in compensation applications presents challenges, it is also an indication that we are being successful in our efforts to expand access to VA benefits.

Investments in transformation of our people, processes, and technologies are already paying off in terms of improved performance. For example:

- ***People***: More than 2,100 claims processors have completed Challenge Training, which improves the quality and productivity of VBA compensation claims decision makers. As a result of Challenge Training, VBA's new employees complete more claims per day than their predecessors – with a 30 percent increase in accuracy.

  VBA's new standardized organizational model incorporates a case-management approach to claims processing that organizes its workforce into cross-functional teams that work together on one of three segmented lanes: express, special operations, or core. Claims that predictably can take less time will flow through an express lane (30 percent); those taking more time or requiring special handling will flow through a special operations lane (10 percent); and the rest of the claims flow through the core lane (60 percent). Initially planned for deployment throughout 2013, VBA accelerated the implementation of the new organizational model by nine months due to early indications of its positive impact on performance.

  VBA instituted Quality Review Teams (QRTs) in 2012 to improve employee training and accuracy while decreasing rework time. QRTs focus on improving performance on the most common sources of error in the claims processing cycle. Today, for example, QRTs are focused on the process by which proper physical examinations are ordered; incorrect or insufficient exams previously accounted for 30 percent of VBA's error rate. As a result of this focus, VBA has seen a 23 percent improvement in this area.

- ***Process***: Disability Benefits Questionnaires (DBQs) are online forms used by non-VA physicians to submit medical evidence. Use of DBQs has improved timeliness and accuracy of VHA-provided exams – average processing time improved by 6 days from June 2011 to October 2012 (from 32 to 26 days).

  Fully developed claims (FDCs) are critical to reducing "wait time" and "rework." FDCs include all DoD service medical and personnel records, including entrance and exit exams, applicable DBQs, any private medical records, and a fully completed claim form. Today, VBA receives 4.5 percent of claims in fully developed form and completes them in 117 days, while a regular claim takes 262 days to process. Fulfilling the Veterans Claims Assistance Act, to search for potential evidence, is the greatest portion of the current 262-day process. The Veterans Benefit Act of 2003 allows Veterans up to 365 days, from the date of VA notice for additional information or evidence, to provide documentation. Of the 262 days to complete a regular claim, approximately145 days are spent waiting for potential evidence to qualify the application as a fully developed claim.

  VBA built new decision-support tools to make our employees more efficient and their decisions more consistent and accurate. Rules-based calculators provide

suggested evaluations for certain conditions using objective data and rules-based functionality. The Evaluation Builder uses a series of check boxes that are associated with the Veteran's symptoms to help determine the proper diagnostic code of over 800 codes, as well as the appropriate level of compensation based on the Veteran's symptoms.

- ***Technology***: The centerpiece of VBA's transformation plan is VBMS – a new paperless electronic claims processing system that employs rules-based technology to improve decision speed and accuracy. For our Veterans, VBMS will mean faster, higher-quality, and more consistent decisions on claims. Our strategy includes active stakeholder participation (Veterans Service Officers, State Departments of Veterans Affairs, County Veterans Service Officers, and Department of Defense) to provide digital electronic files and claims pre-scanned through online claims submission via the eBenefits Web portal.

- VBA recently established the Veterans Claims Intake Program (VCIP). This program will streamline processes for receiving records and data into VBMS and other VBA systems. Scanning operations and the transfer of Veteran data into VBMS are primary intake capabilities that are managed by VCIP. As VBMS is deployed to additional regional offices, document scanning becomes increasingly important as the main mechanism for transitioning from paper-based claim folders to the new electronic environment.

There are other ways that VA is working to eliminate the claims backlog. VHA has implemented multiple initiatives to expedite timely and efficient delivery of medical evidence needed to process a disability claim by VBA. As a result, timeliness improved by nearly one-third, from an average of 38 days in January 2011 to 26 days in October 2012. Recently, VA launched Acceptable Clinical Evidence (ACE), an initiative that allows clinicians to review existing medical evidence and determine whether they can use that evidence to complete a DBQ without requiring the Veteran to report for an in-person examination. This initiative was developed by both VHA and VBA in a joint effort to provide a Veteran-centric approach for disability examinations. Use of the ACE process opens the possibility of doing assessments without an in-person examination when there is sufficient information in the record.

Another way to eliminate the claims backlog is by working closely with the DoD. The Integrated Disability Evaluation System (IDES) is a collaborative system to make disability evaluations seamless, simple, fast and fair. If the Service member is found medically unfit for duty, the IDES gives them a proposed VA disability rating before they leave the service. These ratings are normally based on VA examinations that are conducted using required IDES examination templates. In FY 2012, IDES participants were notified of VA benefit entitlement in an average of 54 days after discharge. This reflects an improvement from 67 days in May 2012 to 49 days in September 2012.

The Benefits Delivery at Discharge (BDD) and Quick Start programs are two other collaborations for Servicemembers to file claims for service-connected disabilities.

This can be done from 180 to 60 days prior to separation or retirement. BDD claims are accepted at every VA Regional Office and at intake sites on military installations in the U.S., and at two intake site locations overseas. In 2012, BDD received more than 30,300 claims and completed 24,944 -- a 14% increase over 2011's productivity (21,657). During this same period of time Quick Start decreased their rating inventory by over 44 percent.

Expanding Access to Benefits and Services

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VA remains committed to ensuring that Veterans are not only aware of the benefits and services that they are entitled to, but that they are able to access them. We are improving access to VA services by opening new or improved facilities closer to where Veterans live. Since 2009, we have added 57 community-based outpatient clinics (CBOCs), for a total of 840 CBOCs through 2013, and increased the number of mobile outpatient clinics and mobile Vet Centers, serving rural Veterans, to 81. Last August, we opened a state-of-the-art medical center in Las Vegas, the first new VAMC in 17 years. The 2014 medical care budget request includes $799 million to open new and renovated healthcare facilities and includes the authorization request for 28 new and replacement medical leases to increase Veteran access to services.

Today, access is much more than the ability to walk into a VA medical facility; it also includes technology, and programs, as well as, facilities. Expanding access includes taking the facility to the Veteran -- be it virtually through telehealth, by sending Mobile Vet Centers to rural areas where services are scarce, or by using social media sites like Facebook, Twitter, and YouTube to connect Veterans to VA benefits and facilities. Telehealth is a major breakthrough in healthcare delivery in 21st century medicine, and is particularly important for Veterans who live in rural and remote areas. The 2014 budget requests $460 million for telehealth, an increase of $388 million, or 542 percent, since 2009.

As more Veterans access our healthcare services, we recognize their unique needs and the needs of their families—many have been affected by multiple, lengthy deployments. VA provides a comprehensive system of high-quality mental health treatment and services to Veterans. We are using many tools to recruit and retain our large mental healthcare workforce to better serve Veterans by providing enhanced services, expanded access, longer clinic hours, and increased telemental health capabilities. In response to increased demand over the last four years, VA has enhanced its capacity to deliver needed mental health services and to improve the system of care so that Veterans can more readily access them. Since 2006, the number of Veterans receiving specialized mental health treatment has risen each year, from over 927,000 to more than 1.3 million in 2012, partly due to proactive screening. Outpatient visits have increased from 14 million in 2009 to over 17 million in 2012. VA believes that mental healthcare must constantly evolve and improve as new knowledge becomes available through research.

The 2014 budget includes $168.5 million for the Veterans Relationship Management (VRM) initiative, which is fundamentally transforming Veterans' access to

VA benefits and services by empowering VA clients with new self-service tools. VA has already made major strides under this initiative. Most recently, in November 2012, VRM added new features to eBenefits, a Web application that allows Veterans to access their VA benefits and submit some claims online. Veterans can now enroll in and manage their insurance policies, select reserve retirement benefits, and browse the Veterans Benefits Handbook from the eBenefits Website. With the help of Google mapping services, the update also enables Veterans to find VA representatives in their area and where they are located. Since its inception in 2009, eBenefits has added more than 45 features allowing Veterans easier, quicker, and more convenient access to their VA benefits and personal information.

VBA has aggressively promoted eBenefits and the ease of enrolling into the system. We currently have over 2.5 million registered eBenefits users. Users can check the status of claims or appeals, review VA payment history, obtain military documents, and perform numerous other benefit actions through eBenefits. The Stakeholder Enterprise Portal (SEP) is a secure Web-based access point for VA's business partners. This electronic portal provides the ability for VSOs and other external VA business partners to represent Veterans quickly and efficiently.

VA also continues to increase access to burial services for Veterans and their families through the largest expansion of its national cemetery system since the Civil War. At present, approximately 90 percent of the Veteran population—about 20 million Veterans—has access to a burial option in a national, state, or tribal Veterans cemetery within 75 miles of their homes. In 2004, only 75 percent of Veterans had such access. This dramatic increase is the result of a comprehensive strategic planning process that results in the most efficient use of resources to reach the greatest number of Veterans.

Ending Veteran Homelessness

The last of our three priority goals is to end homelessness among Veterans in 2015. Since 2009, we have reduced the estimated number of homeless Veterans by more than 17 percent. The January 2012 Point-In-Time estimate, the latest available, is 62,619. We have also created a National Homeless Veterans Registry to track our known homeless and at-risk populations closely to ensure resources end up where they are needed. In 2012, over 240,000 homeless or at-risk Veterans accessed benefits or services through VA and 96,681 homeless or at –risk Veterans were assessed by VHA's homeless programs. Over 31,000 homeless and at-risk Veterans and their families obtained permanent housing through VA specialized homeless programs.

In the 2014 budget, VA is requesting $1.393 billion for programs to assist homeless Veterans, through programs such as Department of Housing and Urban Development-VASupportive Housing (HUD-VASH), Grant and Per Diem, Homeless Registry, and Health Care for Homeless Veterans. This represents an increase of $41 million, or 3 percent over the 2013 enacted level. This budget will support our long-range plan to end Veteran homelessness by emphasizing rescue and prevention --

rescue for those who are homeless today, and prevention for those at risk of homelessness.

Our prevention strategy includes close partnerships with some 150 community non-profits through the Supportive Services for Veteran Families (SSVF) program; SSVF grants promote housing stability among homeless and at-risk Veterans and their families. The grants can have an immediate impact, helping lift Veterans out of homelessness or providing aid in emergency situations that put Veterans and their families at risk of homelessness. In 2012, we awarded $100 million in Supportive Service grants to help Veterans and families avoid life on the streets. We are currently reviewing proposals for the $300 million in grants we will distribute later this year. In 2012, SSVF resources directly helped approximately 21,000 Veterans and over 35,000 household members, including nearly 9,000 children. This year's grants will help up to 70,000 Veterans and family members avoid homelessness. The 2014 budget includes $300 million for SSVF.

To increase homeless Veterans' access to benefits, care, and services, VA established the National Call Center for Homeless Veterans (NCCHV). The NCCHV provides homeless Veterans and Veterans at-risk for homelessness free, 24/7 access to trained counselors. The call center is intended to assist homeless Veterans and their families, VA medical centers, federal, state and local partners, community agencies, service providers, and others in the community. Family members and non-VA providers who call on behalf of homeless Veterans are provided with information on VA homeless programs and services. In 2012, the National Call Center for Homeless Veterans received 80,558 calls (123 percent increase) and the center made 50,608 referrals to VA medical centers (133 percent increase).

VA's Homeless Patient Aligned Care Teams (H-PACTs) program provides a coordinated "medical home" specifically tailored to the needs of homeless Veterans. The program integrates clinical care with delivery of social services and enhanced access and community coordination. Implementation of this model is expected to address health disparity and equity issues facing the homeless population. Expected program outcomes include reduced emergency department use and hospitalizations, improved chronic disease management, and improved "housing readiness" with fewer Veterans returning to homelessness once housed.

During 2012, 119,878 unique homeless Veterans were served by the Health Care for Homeless Veterans Program (HCHV), an increase of more than 21 percent from 2011. At more than 135 sites, HCHV offers outreach, exams, treatment, referrals, and case management to Veterans who are homeless and dealing with mental health issues, including substance use. Initially serving as a mechanism to contract with providers for community-based residential treatment for homeless Veterans, many HCHV programs now serve as the hub for myriad housing and other services that provide VA with a way to outreach and assist homeless Veterans by offering them entry to VA medical care.

VA's Homeless Veterans Apprenticeship Program was established in 2012--a 1-year paid employment training program for Veterans who are homeless or at risk of homelessness. This program created paid employment positions as Cemetery Caretakers at five of our 131 national cemeteries. The initial class of 21 homeless Veterans is simultaneously enrolled in VHA's Homeless Veterans Supported Employment program. Apprentices who successfully complete 12 months of competency-based training will be offered permanent full-time employment at a national cemetery. Successful participants will receive a Certificate of Competency which can also be used to support employment applications in the private sector.

Another avenue of assistance is through Veterans Treatment Courts, which were developed to avoid unnecessary incarceration of Veterans who have developed mental health problems. The goal of Veterans Treatment Courts is to divert those with mental health issues and homelessness from the traditional justice system and to give them treatment and tools for rehabilitation and readjustment. While each Veterans Treatment Court is part of the local community's justice system, they form close working partnerships with VA and Veterans' organizations. As of early 2012 there are 88 Courts.

The Veterans Justice Outreach (VJO) program exists to connect these justice-involved Veterans with the treatment and other services that can help prevent homelessness and facilitate recovery, whether or not they live in a community that has a Veterans Treatment Court. Each VA Medical Center has at least one designated justice outreach specialist who functions as a link between VA, Veterans, and the local justice system. Although VA cannot treat Veterans while they are incarcerated, these specialists provide outreach, assessment and linkage to VA and community treatment, and other services to both incarcerated Veterans and justice-involved Veterans who have not been incarcerated.

Multi-Year Plan for Medical Care Budget

Under the Veterans Health Care Budget Reform and Transparency Act of 2009, which we are grateful to Congress for passing; VA submits its medical care budget that includes an advance appropriations request in each budget submission. The legislation requires VA to plan its medical care budget using a multi-year approach. This policy ensures that VA requirements are reviewed and updated based on the most recent data available and actual program experience.

The 2014 budget request for VA medical care appropriations is $54.6 billion, an increase of 3.7 percent over the 2013 enacted level of $52.7 billion. The request is an increase of $157.5 million above the enacted 2014 advance appropriations level. Based on updated 2014 estimates largely derived from the Enrollee Health Care Projection Model, the requested amount would allow VA to increase funding in programs to eliminate Veteran homelessness; continue implementation of the Caregivers and Veterans Omnibus Health Services Act; fulfill multiple responsibilities

under the Affordable Care Act; provide for activation requirements for new or replacement medical facilities; and invest in strategic initiatives to improve the quality and accessibility of VA healthcare programs. Our multi-year budget plan assumes that VHA will carry over negligible unobligated balances from 2013 into 2014 – consistent with the 2013 budget submitted to Congress.

The 2015 request for medical care advance appropriations is $55.6 billion, an increase of $1.1 billion, or 1.9 percent, over the 2014 budget request. Medical care funding levels for 2015, including funding for activations, non-recurring maintenance, and initiatives, will be revisited during the 2015 budget process, and could be revised to reflect updated information on known funding requirements and unobligated balances.

Medical Care Program

The 2014 budget of $57.7 billion, including collections, provides for healthcare services to treat over 6.5 million unique patients, an increase of 1.3 percent over the 2013 estimate. Of those unique patients, 4.5 million Veterans are in Priority Groups 1-6, an increase of more than 71,000 or 1.6 percent. Additionally, VA anticipates treating over 674,000 Veterans from the conflicts in Iraq and Afghanistan, an increase of over 67,000 patients, or 11.1 percent, over the 2013 level. VA also provides medical care to non-Veterans through programs such the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) and the Spina Bifida Health Care Program; this population is expected to increase by over 17,000 patients, 2.6 percent, during the same time period.

The 2014 budget proposes to extend the Administration's current policy to freeze Veterans' pharmacy co-payments at the 2012 rates, until January 2015. Under this policy, which will be implemented in a future rulemaking, co-payments will continue at $8 for Veterans in Priority Groups 2 through 6 and at $9 for Priority Groups 7 through 8.

The 2014 budget requests $47 million to provide healthcare for Veterans who were potentially exposed to contaminated drinking water at Camp Lejeune as required by the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, enacted last August. Since VA began implementation of the law and in January 2013, 1,400 Veterans have contacted us concerning Camp Lejeune. Of these, roughly 1,100 were already enrolled in VA healthcare. Veterans who are eligible for care under the Camp Lejeune authority, regardless of current enrollment status with VA, will not be charged a co-payment for healthcare related to the 15 illnesses or conditions recognized, nor will a third-party insurance company be billed for these services. In 2015, VA expects to start treating family members as authorized under the law and has included $25 million for this purpose within the 2015 advance appropriations request. VA continues a robust outreach campaign to these Veterans and family members while we press forward with implementing this complex new law.

Mental Healthcare and Suicide Prevention

At VA, we have the opportunity and the responsibility to anticipate the needs of returning Veterans. Mental healthcare at VA is a system of comprehensive treatments and services to meet the individual mental health needs of Veterans. VA is expanding mental health programs and is integrating mental health services with primary and specialty care to provide better coordinated care for our Veteran patients. Our 2014 budget provides nearly $7.0 billion for mental healthcare, an increase of $469 million, or 7.2 percent, over 2013. Since 2009, VA has increased funding for mental health services by 56.9 percent. VA provided mental health services to 1,391,523 patients in 2012, 58,000 more than in 2011.

To serve the growing number of Veterans seeking mental healthcare, VA has deployed significant resources and is increasing the number of staff in support of mental health services. Consistent with the President's August 31, 2012 Executive Order, VHA is on target to complete the goal of hiring 1,600 additional mental health clinical providers and 300 administrative support staff by June 30, 2013 to meet the growing demand for mental health services. In addition, as part of VA's efforts to implement the Caregivers and Veterans Omnibus Health Services Act of 2010, VA has hired over 100 Peer Specialists in recent months, and is hiring and training nearly 700 more. Additionally, VA has awarded a contract to the Depression and Bipolar Support Alliance to provide certification training for Peer Specialists. This peer staff is expected to be hired by December 31, 2013, and will work as members of mental health teams.

In addition to hiring more mental health workers, VA is developing electronic tools to help VA clinicians manage the mental health needs of their patients. Clinical Reminders give clinicians timely information about patient health maintenance schedules, and the High-Risk Mental Health National Reminder and Flag system allows VA clinicians to flag patients who are at-risk for suicide. When an at-risk patient does not keep an appointment, Clinical Reminders prompt the clinician to follow-up with the Veteran.

Since its inception in 2007, the Veterans Crisis Line in Canandaigua, New York, has answered over 725,000 calls and responded to more than 80,000 chats and 5,000 texts from Veterans in need. In the most serious calls, approximately 26,000 men and women have been rescued from a suicide in progress because of our intervention—the equivalent of two Army divisions.

We recently completed a 2012 VA suicide data report, a result of the most comprehensive review of Veteran suicide rates ever undertaken by VA. We are working hard to understand this issue — and VA and DoD have jointly funded a $100 million suicide research project. We will be better informed about suicides, but while research is ongoing, we are taking immediate action and are not waiting 10 years for final study outcomes. These actions include Veterans Chat on the Veterans Crisis Line, local Suicide Prevention Coordinators' for counseling and services, and availability of VA/DoD Suicide Outreach resources.

The Affordable Care Act

The Affordable Care Act (ACA) expands access to coverage, reins in health care costs, and improves the Nation's health care delivery system. The Act has important implications for VA. Beginning in 2014, many uninsured Americans, including Veterans, will have access to quality, affordable health insurance choices through Health Insurance Marketplaces, also known as Exchanges, and may be eligible for premium tax credits and cost-sharing reductions to make coverage more affordable. The 2014 budget requests $85 million within the Medical Care request and $3.4 million within the Information Technology request to fulfill multiple responsibilities as a provider of Minimum Essential Coverage under the Affordable Care Act, including: (1) providing outreach and communication on ACA to Veterans related to VA health care; (2) reporting to Treasury on individuals who are enrolled in the VA healthcare system; and (3) providing a written statement to each enrolled Veteran about their coverage by January 2015.

Medical Care in Rural Areas

VA remains committed to the delivery of medical care in rural areas of our country. For that reason, in 2012, we obligated $248 million to support the efforts of the Office of Rural Health to improve access and quality of care for enrolled Veterans who live in rural areas. Some 3.4 million Veterans enrolled in the VA healthcare system live in rural or highly rural areas of the country; this represents about 41 percent of all enrolled Veterans. For that reason, VA will continue to emphasize rural health in our budget planning, including addressing the needs of American Indian and Alaska Native (AI/AN) Veterans.

VA is committed to expanding access to the full range of VA programs to eligible AI/AN Veterans. Last year, VA signed a Memorandum of Agreement with the Indian Health Service (IHS), through which VA will reimburse IHS for direct care services provided to eligible American Indian and Alaska Native Veterans. While the national agreement applies only to VA and IHS, it will inform agreements negotiated between the VA and tribal health programs.

This follows the agreement already in place between VA and IHS whereby nearly 250,000 patients served by IHS have utilized a prescription program that allows IHS pharmacies to use VA's Consolidated Mail Outpatient Pharmacy (CMOP) to process and mail prescription refills for IHS patients. By accessing the service, IHS patients can now have their prescriptions mailed to them, in many cases eliminating the need to pick them up at an IHS pharmacy.

Women Veterans Medical Care

Changing demographics are also driving change at VA. Today, we have over 2.2 million women Veterans in our country; they are the fastest growing segment of our Veterans' population. Since 2009, the number of women Veterans enrolled in VA

healthcare increased by almost 22 percent, to 591,500. However, by 2022 -- less than a decade from now -- their number is projected to spike to almost 2.5 million, and an estimated 900,000 will be enrolled in VA healthcare.

The 2014 budget requests $422 million, an increase of 134 percent since 2009, for gender-specific medical care for women Veterans. Since 2009, we have invested $25.5 million in improvements to women Veterans' clinics and opened 19 new ones. Today, nearly 50 percent of our facilities have comprehensive women's clinics, and every VA healthcare system has designated women's health primary care providers, and has a women Veteran's program manager on staff.

In 2012, VA awarded 32 grants totaling $2 million to VA facilities for projects that will improve emergency healthcare services for women Veterans, expand women's health education programs for VA staff, and offer telehealth programs to female Veterans in rural areas. These new projects will improve access and quality of critical healthcare services for women. This is the largest number of one-year grants VA has ever awarded for enhancing women's health services.

Medical Research

Medical Research is being supported with $586 million in direct appropriations in 2014, with an additional $1.3 billion in funding support from VA's medical care program and through Federal and non-Federal grants. VA Research and Development will support 2,224 projects during 2014.

Projects funded in 2014 will be focused on supporting development of New Models of Care, identifying or developing new treatments for Gulf War Veterans, improving social reintegration following traumatic brain injury, reducing suicide, evaluating the effectiveness of complementary and alternative medicine, developing blood tests to assist in the diagnosis of post-traumatic stress disorder and mild traumatic brain injury, and advancing genomic medicine.

The 2014 budget continues support for the Million Veteran Program (MVP), an unprecedented research program that advances the promises of genomic science. The MVP will establish a database, used only by authorized researchers in a secure manner, to conduct health and wellness studies to determine which genetic variations are associated with particular health issues – potentially helping the health of America's Veterans and the general public. MVP recently enrolled its 100,000th volunteer research participant, and by the end of 2013, the goal is to enroll at least 150,000 participants in the program.

Veterans Benefits Administration

The 2014 budget request of $2.455 billion for VBA, an increase of $294 million in discretionary funds from the 2013 enacted level, is vital to the transformation strategy that drives our performance improvements focused most squarely on the backlog.

Virtually all 860,000 claims in the VBA inventory, including the 600,000 claims that have been at VA for over 125 days and are considered backlogged, exist only in paper. Our transition to VBMS and electronic claims processing is a massive and crucial phase in VBA transformation. VA awarded two VCIP contracts in 2012 to provide document conversion services that will populate the electronic claims folder, or eFolder, in VBMS with images and data extracted from paper and other source material. Without VCIP, we cannot populate the eFolder on which the VBMS system relies. The 2014 request for $136 million for our scanning services contracts will ensure that we remain on track to reach this key goal. In addition, the budget request includes $4.9 million for help desk support for Veterans using the Veterans On-Line Application/eBenefits system.

VBA projects a beneficiary caseload of 4.6 million in 2014, with more than $70 billion in compensation and pension benefits obligations. We expect to process 1.2 million compensation claims in 2014, and we are pursuing improvements that will enable us to meet the emerging needs of Veterans and their families.

Veterans Employment

Under the leadership of President Obama, VA, DoD, the Department of Labor, and the entire Federal government have made Veterans employment one of their highest priorities. In August 2011, the President announced his comprehensive plan to address this issue and to ensure that all of America's Veterans have the support they need and deserve when they leave the military, look for a job, and enter the civilian workforce. He created a new DoD-VA Employment Initiative Task Force that would develop a new training and services delivery model to help strengthen the transition of our Veteran Servicemembers from military to civilian life. VA has worked closely with other partners in the Task Force to identify its responsibilities and ensure delivery of the President's vision. On November 21, 2012, the effective date of the VOW Act, VA began deployment of the enhanced VA benefits briefings under the revised Transition Assistance Program (TAP), called Transition GPS (Goals, Plans, Success). VA will also provide training for the optional Technical Training Track Curriculum and participate in the Capstone event, which will ensure that separating Servicemembers have the opportunity to verify that they have met Career Readiness Standards and are steered to the resources and benefits available to them as Veterans. Accordingly, the 2014 budget requests $104 million to support the implementation of Transition GPS and meet VA's responsibilities under the VOW Act and the President's Veterans Employment Initiative.

Veterans Job Corps

In his State of the Union address in 2012, President Obama called for a new *Veterans Job Corps* initiative to help our returning Veterans find pathways to civilian employment. The 2014 budget includes $1 billion in mandatory funding to develop a *Veterans Job Corps* conservation program that will put up to 20,000 Veterans back to work over the next five years protecting and rebuilding America. Jobs will include park maintenance projects, patrolling public lands, rehabilitating natural and recreational areas, and administrative, technical, and law enforcement-related activities. Additionally, Veterans will help make a significant dent in the deferred maintenance of our Federal, State, local, and tribal lands including jobs that will repair and rehabilitate trails, roads, levees, recreation facilities and other assets. The program will serve all Veterans, but will have a particular focus on post-9/11 Veterans.

Post 9-11 and other Education Programs

Since 2009, VA has provided over $25 billion in Post-9/11 GI Bill benefits to cover the education and training of more than 893,000 Servicemembers, Veterans, family members, and survivors. We are now working with Student Veterans of America to track graduation and training completion rates.

The Post-9/11 GI Bill continues to be a focus of VBA transformation as it implements the Long-Term Solution (LTS). At the end of February we had approximately 60,000 education claims pending, 70 percent lower than the total claims pending the same time last year. The average days to process Post-9/11 GI Bill supplemental claims has decreased by 17 days, from 23 days in September 2012 to 6 days in February 2013. The average time to process initial Post-9/11 GI Bill original education benefit claims in February was 24 days.

National Cemetery Administration

The 2014 budget includes $250 million in operations and maintenance funding for the National Cemetery Administration (NCA). As we move forward into the next fiscal year, NCA projects our workload numbers will continue to increase. For 2014, we anticipate conducting approximately 121,000 interments of Veterans or their family members, maintaining and providing perpetual care for approximately 3.4 million gravesites. NCA will also maintain 9,000 developed acres and process approximately 345,000 headstone and marker applications.

Review of National Cemeteries

For the first time in the 150-year history of national cemeteries, NCA has completed a self-initiated, comprehensive review of the entire inventory of 3.2 million headstones and markers within the 131 national cemeteries and 33 Soldiers' Lots it maintains. The information gained was invaluable in validating current operations and

ensuring a sustainment plan is in place to enhance our management practices. The review was part of NCA's ongoing effort to ensure the full and accurate accounting of remains interred in VA national cemeteries. Families of those buried in our national shrines can be assured their loved ones will continue to be cared for into perpetuity.

Veterans Employment

NCA continues to maintain its commitment to hiring Veterans. Currently, Veterans comprise over 74 percent of its workforce. Since 2009, NCA has hired over 400 returning Iraq and Afghanistan Veterans. In addition, 82 percent of contracts in 2012 were awarded to Veteran-owned and service-disabled Veteran-owned small businesses. NCA's committed, Veteran-centric workforce is the main reason it is able to provide a world-class level of customer service. NCA received the highest score—94 out of 100 possible—in the 2010 American Customer Satisfaction Index (ACSI) sponsored by the University of Michigan. This was the fourth time NCA participated and the fourth time it received the top rating in the Nation.

Partnerships

NCA continues to leverage its partnerships to increase service for Veterans and their families. As a complement to the national cemetery system, NCA administers the Veterans Cemetery Grant Service (VCGS). There are currently 88 operational state and tribal cemeteries in 43 states, Guam, and Saipan, with 6 more under construction. Since 1978, VCGS has awarded grants totaling more than $500 million to establish, expand, or improve Veterans' cemeteries. In 2012, these cemeteries conducted over 31,000 burials for Veterans and family members.

NCA works closely with funeral directors and private cemeteries, two significant stakeholder groups, who assist with the coordination of committal services and interments. Funeral directors may also help families in applying for headstones, markers, and other memorial benefits. NCA partners with private cemeteries by furnishing headstones and markers for Veterans' gravesites in these private cemeteries. In January of this year, NCA announced the availability of a new online funeral directors resource kit that may be used by funeral directors nationwide when helping Veterans and their families make burial arrangements in VA national cemeteries.

Capital Infrastructure

A total of $1.1 billion is requested in 2014 for VA's major and minor construction programs. The capital asset budget reflects VA's commitment to provide safe, secure, sustainable, and accessible facilities for Veterans. The request also reflects the current fiscal climate and the great challenges VA faces in order to close the gap between our current status and the needs identified in our Strategic Capital Investment Planning (SCIP) process.

Major Construction

The major construction request in 2014 is $342 million for one medical facility project and three National Cemeteries. The request will fund the completion of a mental health building in Seattle, Washington, to replace the existing, seismically deficient building. It will also increase access to Veteran burial services by providing a National Cemetery in Central East Florida; Omaha, Nebraska; and Tallahassee, Florida.

The 2014 budget includes $5 million for NCA for advance planning activities. VA is in the process of establishing two additional national cemeteries in Western New York and Southern Colorado, according to the burial access policies included in the 2011 budget. These two new cemeteries, along with the three requested in 2014, will increase access to 550,000 Veterans. NCA has obligated approximately $16 million to acquire land in 2012 and 2013 for the planned new national cemeteries in Central East Florida; Tallahassee, Florida; and Omaha, Nebraska.

Minor Construction

In 2014, the minor construction request is $715 million, an increase of 17.8 percent from the 2013 enacted level. It would provide for constructing, renovating, expanding and improving VA facilities, including planning, assessment of needs, gravesite expansions, site acquisition, and disposition. VA is placing a funding priority on minor construction projects in 2014 for two reasons. First, our aging infrastructure requires a focus on maintenance and repair of existing facilities. Second, the minor construction program can be implemented more quickly than the long-term major construction program to enhance Veterans' services.

In light of the difficult fiscal outlook for our Nation, it's time to carefully consider VA's footprint and our real property portfolio. In 2012, VA spent approximately $23 million to maintain unneeded buildings. Achieving significant reduction in unneeded space is a priority for the Administration and VA. To support this priority, the President has proposed a Civilian Property Realignment Act (CPRA), which would allow agencies like VA to address the competing stakeholder interests, funding issues, and red tape that slows down or prevents the Federal Government from disposing of real estate. If enacted by Congress, this process would give VA more flexibility to dispose of property and improve the management of its inventory.

Legislation

Besides presenting VA's resource requirements to meet our commitment to the Nation's Veterans, the President's Budget also requests legislative action that we believe will benefit Veterans. There are many worthwhile proposals for your consideration, but let me highlight a few. For improvements to Veterans healthcare, our budget includes a measure to allow VA to provide Veterans with alternatives to long-stay nursing homes, and enhance VA's ability to provide transportation services to assist Veterans with accessing VA healthcare services. Our legislative proposasl also

request that Congress make numerous improvements to VA's critical homelessness programs, including allowing an increased focus on homeless Veterans with special needs, including women, those with minor dependents, the chronically mentally ill, and the terminally ill.

We also are putting forward proposals aimed squarely at the disability claims backlog – such as establishing standard claims application forms—that are reasonable and thoughtful changes that go hand-in-hand with the ongoing transformation and modernization of our disability claims system. We are offering reforms to our Specially Adaptive Housing program that will remove rules that in some circumstances can arbitrarily limit the benefit. The budget's legislative proposals also include ideas for expanding and improving services in our national cemeteries.

Finally, this budget includes provisions that will benefit Veterans and taxpayers by allowing for efficiencies and cost savings in VA's operations – for example, we are forwarding a proposal that would require that private health plans treat VA as a 'participating provider' – preventing those plans from limiting payments or excluding coverage for Veterans' non-service-connected conditions. VA merits having this status, and the additional revenue will fund medical care for Veterans. We are also requesting spending flexibility so that we can more effectively partner with other federal agencies, including DoD, in pursuit of collaborations that will benefit Veterans and Servicemembers and deliver healthcare more efficiently.

Summary

Veterans stand ready to help rebuild the American middle class and return every dollar invested in them by strengthening our Nation. And we, at VA, will continue to implement the President's vision of a 21st century VA, worthy of those who, by their service and sacrifice, have kept our Nation free. Thanks to the President's leadership and the solid support of Congress, we have made huge strides in our journey to provide all generations of Veterans the best possible care and benefits through improved technology that they earned through their selfless service. We are committed to continue that journey, even as the numbers of Veterans using VA services increase in the coming years, through the responsible use of the resources provided in the 2014 budget and 2015 advance appropriations requests. Again, thank you for the opportunity to appear before you today and for your steadfast support of our Nation's Veterans.

Department of Veterans Affairs

Washington, D.C.

Robert A. Petzel, M.D.

Under Secretary for Health

Robert A. Petzel, M.D., was appointed Under Secretary for Health in the Department of Veterans Affairs (VA) on Feb. 18, 2010. Prior to this appointment, Dr. Petzel had served as VA's Acting Principal Deputy Under Secretary for Health since May 2009.

As Under Secretary for Health, Dr. Petzel oversees the health care needs of millions of veterans enrolled in the Veterans Health Administration (VHA), the nation's largest integrated health care system. With a medical care appropriation of more than $48 billion, VHA employs more than 262,000 staff at over 1,400 sites, including hospitals, clinics, nursing homes, domiciliaries, and Readjustment Counseling Centers. In addition, VHA is the nation's largest provider of graduate medical education and a major contributor to medical research. More than eight million veterans are enrolled in the VA's health care system, which is growing in the wake of its eligibility expansion. This year, VA expects to treat nearly six million patients during 78 million outpatient visits and 906,000 inpatient admissions.

Previously, Dr. Petzel served as Network Director of the VA Midwest Health Care Network (VISN 23) based in Minneapolis, Minn. In that position, Dr. Petzel was responsibility for the executive leadership, strategic planning and budget for eight medical centers and 42 community-based outpatient clinics, serving veterans in Iowa, Minnesota, Nebraska, North Dakota, South Dakota, western Illinois and western Wisconsin.

Dr. Petzel was appointed Director of Network 23 (the merger of Networks 13 and 14) in October 2002. From October 1995 to September 2002, he served as the Director of Network 13. Prior to that position, he served as Chief of Staff at the Minneapolis VA Medical Center.

Dr. Petzel is particularly interested in data-based performance management, organization by care lines, and empowering employees to continuously improve the way we serve our veterans. He is involved in a collaborative partnership with the British National Health Services Strategic Health Authority. In addition, he co-chairs the National VHA Strategic Planning Committee and the VHA System Redesign Steering Committee.

Dr. Petzel graduated from St. Olaf College, Northfield, Minn., in 1965 and from Northwestern University Medical School in 1969. He is Board Certified in Internal Medicine and on the faculty of the University of Minnesota Medical School.

March 2010

Allison A. Hickey
Under Secretary for Benefits

Department of Veterans Affairs
Washington, D.C.

Retired Brig. Gen. Allison A. Hickey assumed the duties of Under Secretary for Benefits at the Department of Veterans Affairs (VA) on June 6, 2011.

As Under Secretary for Benefits, Hickey leads more than 20,000 employees in the delivery of a wide range of integrated programs of nonmedical benefits and services to Veterans, their dependents and survivors. Through a nationwide network of 57 regional offices, special processing centers, and VBA Headquarters, she directs the administration of VA's disability compensation, pension, education, home loan guaranty, vocational rehabilitation and employment, and life insurance programs, and an annual budget of more than $72.3 billion.

Prior to her appointment, Hickey led Human Capital Management for the consulting company Accenture in their work for the National Geospatial- Intelligence Agency – supporting operational business processes for intelligence community organizations in the areas of customer relationship management, call center practices and 21st Century information technology systems.

As the Director of the Air Force's Future Total Force office at the Pentagon, she provided leadership and oversight for four divisions in the areas of strategic planning, mission development, public and congressional affairs and program and resource implementation for more than 140 new Air Force units. Hickey was responsible for shifting billions of dollars towards new capabilities across the Air Force portfolio and directing new organizational models for a world-wide 500,000 person organization including active duty, Air National Guard and Air Force Reserve units and personnel to create a common Air Force policy, mission, and culture – known in the Department as the Total Force Perspective.

Prior to that assignment, Hickey served as the assistant deputy director of Strategic Planning, where she provided leadership and oversight for five divisions. She also served as chief of the Air Force Future Concepts and Transformation Division focused on the integration of technologies, organizations and concepts of operation to model for the Air Force of 2025.

Hickey is a 27-year Veteran of the Air Force having served on active duty, in the Air National Guard and the Air Force Reserves. Her Air Force career began in 1980 as a graduate of the U.S. Air Force Academy's first class to include women. As a pilot and aircraft commander, she accumulated more than 1,500 hours of flight time in KC-10A, KC-135A, T-38 and T-37 aircraft. She is the daughter of retired Lt. Gen. William J. Hilsman, a Vietnam Army Veteran, and Jean Hilsman, who served as a director and past-president of the National Military Family Association and as the first Department of Defense Family Policy Office director.

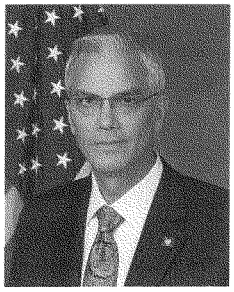
Hickey is married to retired Col. Robert Hickey, a 30-year Veteran and former A-10 and C-130 pilot. She and her husband have three children and live in Ashburn, VA.

January 2012

Department of Veterans Affairs

Washington, D.C.

W. Todd Grams



Executive in Charge for the Office of Management and Chief Financial Officer

W. Todd Grams was appointed as the Principal Deputy Assistant Secretary for Management for the Department of Veterans Affairs (VA) on November 8, 2009. In addition, he serves as Executive in Charge for the Office of Management for the Department. He is responsible for the budget and financial management of VA's $125 billion budget as well as the Department's performance management, business oversight, and asset enterprise management programs.

Before his appointment at the VA, Mr. Grams served as the Chief Financial Officer (CFO) at the U.S. Department of Commerce's National Institute of Standards and Technology from July 2006 to November 2009. In that position, he was responsible for all NIST-wide administrative offices including: information technology, human resources, facilities, construction, finance, acquisitions, grants, budget, safety and security.

From 2003 to 2006, Mr. Grams served as the Chief Information Officer (CIO) of the Internal Revenue Service (IRS) where he was responsible for all IRS IT functions nationwide, totaling $2 billion and 7,000 staff. His three-year tenure is the longest of any agency-wide IRS CIO, and he led the most successful years to date of the IRS modernization program, while restructuring 15 percent of the IT workforce. From 2001 to 2003, he was the CFO of the IRS where he was responsible for the accounting of $2 trillion in tax receipts and the oversight of the IRS' $10 billion operating budget.

Prior to joining the IRS, he served at the VA from 1994 to 2000 as the first CFO of the Veterans Health Administration (VHA) where he was responsible for budget, finance, CHAMPVA, Medical Care Cost Recovery, DOD-VA Sharing, and acquisitions. In this position, he led the development of the ground-breaking Veterans Equitable Resource Allocation system, which after 12 years continues to be the internal allocation system used by the VHA. In 2001, he served as the VA's Deputy Chief Financial Officer.

Mr. Grams began his Federal service at the Bureau of the Census in 1980 as a budget analyst. He served in a variety of positions at the Office of Management and Budget from 1983 to 1994, including appropriations bill tracker, budget examiner, and Chief of the Veterans Affairs Branch.

Mr. Grams has earned three Presidential Rank Awards. He received the Presidential Rank Award for Distinguished Service in 2006 (while with the IRS) and in 2000 (while with the VA). In 1997, he received the Presidential Rank Award for Meritorious Service at the VA. In addition, he is the recipient of the Department of Veterans Affairs Secretary's Awards for Distinguished Career and Meritorious Service.

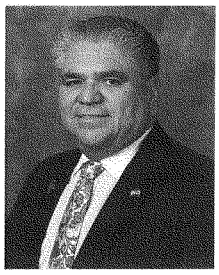
Mr. Grams graduated from the University of Maryland with a Bachelor of Arts degree in Economics in 1980.

June 2011

Department of Veterans Affairs

Steve L. Muro

Washington, D.C.



Under Secretary for Memorial Affairs

Steve L. Muro was sworn in as the Under Secretary for Memorial Affairs on June 6, 2011. As Under Secretary, he leads 131 National Cemeteries in providing dignified burial services for military Veterans and eligible family members. His responsibilities also include: maintaining the cemeteries as national shrines; land acquisition, design, construction, and other activities relating to the establishment of new national cemeteries; overseeing other memorial programs to honor the service of deceased Veterans, including provision of headstones, markers, medallions and Presidential Memorial Certificates; and administering federal grants to help states, territories and tribal governments establish Veterans cemeteries.

Under Mr. Muro's leadership, the National Cemetery Administration (NCA) developed an unsurpassed record of achievement on the American Customer Satisfaction Index (ACSI). For the 2010 survey, and for the fourth consecutive time in 10 years, NCA attained the highest ranking of any participating entity, besting over 100 other federal agencies and industry leaders like Ford, FedEx and Coca Cola.

Mr. Muro's life's work has been linked with the mission of NCA. Prior to this appointment, he served as Deputy Under Secretary and then Acting Under Secretary for Memorial Affairs. From February 2003 to October 2008 he was Director of the Office of Field Programs, and also served as its Acting Director from December 2002 to February 2003. In these roles, he provided leadership and direction to agency field offices and facilities and guided NCA through the largest expansion of the cemetery system since the Civil War. During his tenure, he initiated a new NCA Training Center to centralize and provide consistent training to employees. The first priority for the new center was implementation of a yearlong resident training program for Cemetery Director Interns. Seeing a further need to increase efficiency, he led the process to create a National Cemetery Scheduling Office and a centralized Human Resources function to support all national cemeteries.

Mr. Muro began his NCA career in 1978 as an automotive mechanic at Los Angeles National Cemetery. He then held multiple positions of increasing responsibility, including Directorships and Assistant Directorships at seven national cemeteries and the Memorial Service Network V, headquartered in Oakland, Calif.

Mr. Muro served in the U.S. Navy from 1968 to 1972, including two tours of duty in Vietnam: on board USS Benjamin Stoddert (DDG-22) and with the Seabees of Mobile Construction Battalion TEN.

He is a graduate of Mt. San Antonio Junior College, Leadership VA, the Federal Executive Institute, and the Senior Executive Service Candidate Development Program. In 2008, Mr. Muro was selected by the President of the United States to receive a Presidential Meritorious Rank Award. Awarded to fewer than five percent of senior federal executives, the award recognizes exceptional leadership, accomplishments and service over an extended period of time.

June 2011

Stephen Warren
Acting Assistant Secretary
Department of Veterans Affairs

Stephen Warren joined the Department of Veterans Affairs in May 2007 as the first Principal Deputy Assistant Secretary in the Office of Information and Technology (PDAS/IT) and is currently the Acting Assistant Secretary and Chief Information Officer for the Department. In his role as PDAS, Stephen is the Chief Operating Officer of the $3.3 billion, 8,000 employee IT organization, overseeing the day-to-day activities of the IT organization to ensure VA's employees have the IT tools and services needed to support our Nation's Veterans. Stephen successfully led the consolidation of VA's vast IT network into one of the largest consolidated IT organizations in the world.

Stephen has over 30 years of federal experience. Previously, Stephen served as the CIO at the Federal Trade Commission, joining in December 2001. Among other accomplishments at the FTC, Stephen managed the successful implementation of the Commission's National Do Not Call Registry in 2003. Prior to the FTC, Stephen served for ten years at the Department of Energy (DOE). His last position at DOE was as the Chief Information Officer for the Office of Environmental Management, a $6 billion per year program responsible for managing the cleanup of former nuclear weapon production sites. Before working at DOE, Stephen served for nine years on active duty in the Air Force where he was involved in a broad range of activities including: research in support of the Strategic Defense Initiative (SDI), support for nuclear treaty monitoring efforts, and service in Korea as a transportation squadron section commander.

Stephen is a 1982 graduate of the University of Michigan, where he received a B.S. in Nuclear Engineering. He received a M.S. in Systems Management from the Florida Institute of Technology. He is widely published on subjects involving nuclear facilities, radioactivity, and related issues. He is an accomplished speaker on a range of topics including information security, project management, and managing change.

Stephen was recognized by Federal Computer Week as one of the Federal 100 award winners for 2012 and 2004. He received the Presidential Rank Award of Distinguished Executive in 2008. He is a recipient of the 2006 Government Information Security Leadership Award (GISLA). Stephen was awarded the 2004 Service to America Social Services Medal, as one of the managers of the FTC's National Do Not Call registry. He led the IT team that received the 2004 AFFIRM (Association for Federal Information Resources Management) Leadership Award for Innovative Applications and one of five federal 2004 American Council for Technology Intergovernmental Solutions awards. He is a founding member of the CIO Executive Council, and a member of the CIO Executive Council Advisor Board.

Mr. CULBERSON. Mr. Secretary, in the interest of time, I will keep my questions fairly short and to the point in order to give everyone a chance to visit with you before the vote occurs.

PROCESSING CLAIMS

The number of claims being submitted have increased every year. The new automated system is still not operating nationwide. You have been working on this for years, promised us for years that this would be resolved. You say you are still on target to hit that 2015 deadline, but the number of completed claims continues to fall below projections. The average number of days it takes to complete a claim continues to grow, and accuracy levels are still below all the targets that you have set.

What is the VA doing differently that would enable the community to believe that you can meet your goal of no claim taking longer than 125 days and claims determination being accurate in 98 percent of cases?

Secretary SHINSEKI. Mr. Chairman, let me just describe what we have been about, which is a robust plan. Congress has been very supportive, and we are executing that plan as we speak.

Now, if we can think back 4 years ago, our system was paper because we received paper. Everything we received from DOD is in paper. The records that Congresswoman Lowey demonstrated in Winston-Salem, my understanding is today those records have been cleared up. But needless to say, those are records that follow members around their tour in the military, and that is what we receive for processing. This is what we are trying to change, this juggernaut of paper that comes our way. Veterans submit their claims in paper, usually accompanied by some of those records as well.

So, we have to change that. We have hired more claims processors throughout the years, and still the number of claims, because after over a decade of war, continues to grow. We have to change our approach here and what we have developed is a movement of automation. In order to move to automation, we have to create an automation tool that others can send electrons to. DOD has agreed to do this. By the end of this year, we will be receiving electrons, that is the commitment from DOD. All that paper that has been coming our way is beginning to change.

We have over 800,000 claims in paper today. The ones that we have begun processing will continue in paper and finish out. The ones that we think are able to be scanned and put into the database are being scanned. That is a work in progress. What we have been about for the last 2 years is developing an automation tool that has the capability and the power to make this transition. We have done that. That program is called VBMS. We are fielding it today. We are in 36 of the 56 regional offices.

As I said, we had set aside this entire year to field 56 locations. My guess is we are going to be finished early, and when we have that system in place, an automation tool and DOD feeding us electrons, veterans will have an ability to file online, provide us their claims electronically, and scan in the documents that they would like to submit for consideration. We are in the process of creating a major transformation.

MEETING THE 2015 DEADLINE

Mr. CULBERSON. Yes, sir. I appreciate that, and my question, though, is what is the VA doing differently or new that would convince the Congress that you can meet this 2015 deadline? With all due respect, sir, that is basically the same things we have heard for the last many years. I have to say, based on the performance so far and the continuing increase in the amount of time it takes to handle a claim, the continuing problems, the tremendous increase in funding that we have given you, and all the support and love and encouragement we can give you, and we still haven't seen the changes, I can now see why some of my colleagues have said that the VA should be required to simply turn claims processing over to the private sector with a performance-based contract that would make funding contingent on speed and accuracy metrics. Under this scenario, current VA claims processors would have to compete for their job with the private sector, with a private company that would win the competition to process claims.

The goal here is to serve veterans. The goal is to ensure that our veterans are given the support and the help that they have earned to their service to the country. And the work is so vital and so important, I just don't see how we can simply continue the way we have. In fact, based on everything I have seen and heard in the time that Chairman Rogers has entrusted me with this extraordinary privilege of being the chairman of this subcommittee, I just haven't seen much change.

TURNING BACKLOG OVER TO PRIVATE SECTOR

So, why shouldn't the Congress go ahead and change the law that by 2015, in 20 months; if you haven't met your deadline, create a situation where the private sector can step in and handle this for you, and those folks that are not doing their job with the VA, just simply turn over the responsibilities to a private company to make sure that our veterans are given the benefits that they have earned?

Secretary SHINSEKI. Fair enough, Mr. Chairman. I think what I have described is a robust plan here to accomplish what we all want, which is no veteran should have to wait for any claim, that is for disabilities that they have earned and incurred. I think we are all committed to that.

This is an ambitious plan. At the same time that we began this transition of VA, DOD and all the inputs, we also added to our workload to take care of some unfinished business. Vietnam veterans and Agent Orange, for 47 years have not been recognized for three key diseases. We added that to the workload, knowing that it was going to increase inventory and slow the backlog or increase the backlog. We testified to that 2 to 3 years ago, and we said that this was the right thing to do, and we were going to do it. To accept this increase, we were going to work through this and develop an automation tool, VBMS. It is in the process of being delivered.

We also, for 20 years have not acknowledged Gulf War illness for veterans who served in Desert Storm One. There were a variety of indicators that they had healthcare issues, never recognized, but 3

years ago we said we were going to do something about it. For the first time ever, we don't have a clear cause of these maladies.

Mr. CULBERSON. Yes, sir.

Secretary SHINSEKI. In the past we have always said we are going to find a cause before we grant. We decided there were nine diseases that had a sufficient enough population for us to say we don't know what caused it, but something obviously happened. We will treat those symptoms and then deal with the disability claims.

CONGRESS LETTING PRIVATE SECTOR COMPETE

Mr. CULBERSON. Yes, sir. My question was, though, why shouldn't we in Congress go ahead and create a mechanism and let the private sector compete for this. In 20 months, your deadline is 2015, if you can't meet it, we will go ahead and let the private sector come in and step up to the plate.

And then I will turn it over to Mr. Bishop.

Secretary SHINSEKI. Well, I think we have indicators now that the plans we have in place have the results we are beginning to see to bear fruit, and this will continue to show over 2013 and into 2014. I remain confident that 2015 is a good target for us.

We have done employee training, and more claims per day are being completed, a 30 percent increase in accuracy. We have, as I said, segmented lanes, where we have a fast lane and a special lane and a lane for the vast majority of claims. Productivity has already shown a 10 percent increase in offices that have gone this route.

Disability claims questionnaires have speeded up processing and increased our production by 60,000 claims. We are moving to a rules-based engine for the VBMS program that we are currently fielding. As soon as we are done fielding it, we are looking for the opportunity to insert a rule-based device, like a TurboTax capability, where the right data fills the blocks, and decisions are made, and checks are cut.

Fifty-two calculators for fifteen disability body systems have been reviewed and are integrated into VBMS, and we expect that accuracy alone will rise to 92 percent.

You know, I think we have a good plan in place. It is a robust plan. We have been building it for 2 years now. We have just begun fielding VBMS 6 months ago, and we are in 36 locations.

Mr. CULBERSON. Well, you know how strongly we support you. The Committee and the Congress have given you everything you have asked for to do what has to be done so that our veterans who have earned these benefits can receive them in a timely fashion. And I tell you, if it doesn't happen, I think we should look at a radical restructuring and some changes to make sure those men and women get what they have earned.

Secretary SHINSEKI. Mr. Chairman.

Mr. CULBERSON. We really got to rethink this.

Secretary SHINSEKI. Well, Mr. Chairman, I thank you——

Mr. CULBERSON. Do something different.

Secretary SHINSEKI [continuing]. For the support of the Congress. I mean, it has been crucial.

CLAIMS INVENTORY

But just so we are not sitting here thinking there is nothing happening, we have averaged a million claims decisions going out the door for the last 4 years, so when you are talking about a claims inventory of about 870,000 claims.

The backlog is clearly larger than it needs to be at roughly 600,000, but when you are putting a million claims out the door with an inventory of 870,000 claims, there is work being done.

Mr. CULBERSON. Thank you, sir.

Secretary SHINSEKI. It is not a static number of claims.

Mr. CULBERSON. I need to move to Mr. Bishop.

Mr. Bishop.

Mr. BISHOP. Thank you very much.

Mr. Secretary, while I share the chairman's frustration, I do have some serious reticence about suggesting that contractors could do the work. Our experience with DOD and with most of the agencies where we have utilized contractors is that contractors have cost significantly more to the government, to the taxpayers to produce the results that were done by the civil service employees. That has been documented particularly in the Department of Defense. So I am not so sure that that would be the stick that we would hold over the Department's head, but we are very, very frustrated, and we expect that something has to be done.

Another item from your testimony that caught my attention, which I guess just highlights the challenges that you face, is that the average number of claimed conditions for recently separated servicemembers, which is now in the 12 to 16 range, is an increase in the number of disabilities claimed by veterans of earlier years.

CLAIMS VERIFICATION

Do claims processors have to have all the claimed conditions verified before the claim can be processed, or as conditions are verified, the claim for that condition approved?

Secretary SHINSEKI. I think the increase in the number of issues per claim is reflective of the complexity of the operation. The fact that we have improved battlefield medicine, with evacuations, we have many, many more surviving the injuries that have traditionally been associated with warfare, and therefore, folks who return to us have more complex injuries and more issues to be dealt with.

Mr. BISHOP. So that means that it takes longer for the claim to actually be developed, in the process, and you can submit it for the record or get back with us, but I am interested to know whether or not, if they have these multiple issues, if all of those issues have to be developed in order for any of the claims to be processed.

Secretary SHINSEKI. It takes longer. I think——

Mr. BISHOP. Wait until the end to rule on the claim until they have dealt with all 12 to 16 different issues as opposed to some that are clear and some that are not so clear?

Secretary SHINSEKI. What we do is if there are that many issues with a claim, we will decide those that are clearly resolvable, and make those decisions, and begin to address the disability claims payments. But by the current rules, if you take care of 14 of the 16, and the veteran is being cared for and being compensated, be-

cause those 2 remaining issues are still unresolved, the claim remains open and it counts as a backlog claim, even though you have completed a good portion of the work. I can provide a greater detail for the record.

[The information follows:]

VA's claims adjudication manual authorizes claims personnel to make an intermediate rating decision if the record contains sufficient evidence to grant any contention at issue, including service connection at a non-compensable level. (M21–1MR III.iv.6.A.1.a) Exercising this authority ensures that Veterans are afforded entitlement to benefits at the earliest possible date; however, issuing this partial decision does not resolve the pending claim. Such claims remain pending until all contentions associated with it are developed and decided back to the original date of claim. Thus, if the claim has been pending more than 125 days, it would still be considered part of the backlog inventory.

Mr. BISHOP. Thank you. That is some explanation, but not satisfaction for why you are experiencing the challenges that you are.

LINK BETWEEN VA AND DOD

I want to get back to the integrated electronic health records. Your Department and the Department of Defense were directed repeatedly by Congress to develop an electronic health record system that would follow a servicemember from enlistment to the time that they exited, But because of the problems that you and Secretary Panetta encountered, you decided to alter that original goal of the iEHR and to focus on making the systems more interoperable.

VistA will be your core system. Have you been given any indication of what core system the Department of Defense is going to choose? And with Secretary Hagel being familiar with the VistA system, given his time at the VA, have you recommended the VistA system to DOD, and what effect would having the same system have on your claim backlog?

GOAL OF IEHR

And I noticed that in your 2014 budget request, you included $251 million for the iEHR. Can you explain what that money is going to be used for since you have altered the original goal for the iEHR?

Secretary SHINSEKI. Certainly, Congressman. This has been an ongoing discussion now between Secretary of Defense and Secretary of VA for at least 4 years. Let me just say, I spent 38 years in uniform, and in those 38 years I knew there was a VA, but I didn't know what the VA did, and so, frankly, my whole focus and my time in DOD was preparing to go on mission. That is the mission they should be focused on.

Mr. BISHOP. And taking care of soldiers.

Secretary SHINSEKI. Our responsibility then is, between the Departments, to ensure that we are being supportive of DOD's responsibilities here. As I have said before in testimony, very little of what we work on in VA originates here; most of what we work on originates in DOD, and that is not a negative. That reminds us of our important link between VA and DOD. It is not a link I understood for 38 years until I came here, and so the earliest discussions with Secretary Gates was this effort to change the relationship, and that has been under way between the two Secretaries.

The cultures in the two Departments are a little different because of their national security missions, but we have worked very hard in the last 4 years to bring the two Departments together, and one of the signature efforts has been this electronic health record. We agreed in the past that that electronic health record would have certain key words associated with it, single, joint, common, integrated electronic health record, all of that code, to ensure that we stayed on a very focused approach to resolving this issue. We added to it open in architecture, nonproprietary in design, and all of that was, again, to focus us on a solution that would be a single record that we would both share.

Mr. BISHOP. DOD agreed with the nonproprietary?

Secretary SHINSEKI. That definition has been agreed to, and my discussions with Secretary Hagel shortly after his arrival was he wanted some time to get into his own Department, figure out how that translated, make sure it had the right structure in place, and I believe that is what you are receiving testimony about. He has decided to make some adjustments to the structure, and then he and I will meet. I look forward to that.

DIFFERENCES BETWEEN DOD-VA SYSTEMS

Mr. BISHOP. Your system is not proprietary, but the DOD system in the past is proprietary. The government owns your system.

Secretary SHINSEKI. Yes.

Mr. BISHOP. We have full control of it. But the one that is utilized by the DOD is proprietary, and contractors——

Secretary SHINSEKI. I am not quite as familiar with DOD's current contract, but I believe that is correct. That it is a contractor-provided system. Ours is government-owned, government-operated program and, in fact, we have taken our code and put it into the open architecture so that anyone who wants to has access to it and can use it.

I believe between DOD and VA, we have the opportunity to create an electronic health record that has these dimensions to it that will benefit many others in this country who couldn't afford to do the kind of research development that we do. We both look forward to being able to provide that.

Mr. BISHOP. Thank you, Mr. Secretary.

Mr. CULBERSON. Thank you, Mr. Bishop.

Chairman Rogers.

Mr. ROGERS. Thank you, Mr. Chairman.

On the claims backlog, I know now that you are moving rapidly to digitalize the claims, which I think is the only way to go. That allows you to move these cases so much quicker, and I salute you for that.

On the electronic health records, since 2008, between DOD and the VA, we have spent about $537 million to create this integrated electronic health record with very little to show for it. The effort was made to combine the two into one. That apparently has fallen by the boards, and now apparently we are trying to integrate the two systems to make them interoperable. Am I generally correct in that statement?

Secretary SHINSEKI. Mr. Chairman, we have two records today.

Mr. ROGERS. Yes.

Secretary SHINSEKI. We have created what I call a GUI, a graphical user interface, that allows a physician to pull data out of each system. If I am seeing a veteran, and I want to see what is in his military record, I can reach into DOD's database and get that information.

It is awkward, it is slow, but it is interoperable, and you can make it better, but it isn't where we want to go. We are looking at a single electronic record that is seamless between us. I just think in the long run that serves both Departments, and I look forward to my discussions with Secretary Hagel.

We don't want to end up, again, with a decision that has two records that in time get developed in ways that no longer talk to each other, because we know that the speed at which healthcare improvements are occurring, we are going to want to add capabilities, and we need to do this in a seamless way so that each of us have a record that reflects those improvements.

Mr. ROGERS. Well, you and have I shared this information before about the young man that came to see me a few years ago, a veteran from Iraq that had been in an IED explosion to his head and face. It ruined one eye, but the other eye was reasonably well, but then it began to deteriorate after he came home. He went to the Lexington VA hospital. They were unable to operate, to save this eye, because they could not get the records of the DOD when he was first treated after being injured, and they were afraid to operate again here in the head area because they just didn't know what they were facing. As a consequence, he lost the second eye.

That is unforgivable. I know you and I have talked about this before, and there must be a lot of cases just like that that are happening today. We simply can't violate the honor that our soldiers have given to us by that kind of ineptitude. Tell me that that won't happen today.

Secretary SHINSEKI. Well, I will first agree with you, Mr. Chairman, that that is a horrible reflection of two Departments being unable to provide the information where we can deliver health care. We are working; as I say, today we are better than we were 3 years ago. We now have this ability to pull out of each of our databases. It isn't good enough. We are headed to a seamless system where we can share that information back and forth across our boundaries. There are active duty soldiers who are treated in VA facilities, and then they go back to Department of Defense service. We have to be seamless here, and this is what we are working towards, your statement, Mr. Chairman, about that should never happen again.

Mr. ROGERS. Well, this has human consequences in what we are talking about. It is not just electronic information.

Let me touch briefly, Mr. Chairman, if I have the time——

Mr. CULBERSON. Certainly.

PRESCRIPTION DRUG ABUSE

Mr. ROGERS [continuing]. On another problem that really bothers me over the years, and that is prescription drug abuse. I know you are working in this arena very, very much.

One of the things that I think we could do is to require mandatory physician training on the dangers of prescription overuse. The

rate of prescriptions for medical problems in the military is skyrocketing. After the 2010 report of the Army's, "Pain Management Task Force," DOD announced plans to expand drug testing for unauthorized prescription drugs, and we have seen a huge increase in the reported symptoms of PTSD strongly associated with substance abuse and dependence.

The pain reliever prescriptions written by military physicians quadrupled between 2001 and 2009. I know we have had the combat-related injuries that require these medicines, and I know that it is difficult for us to judge whether or not the problem is solely related to an increase in the number of injuries received in warfare, but having even included that in our calculations, we are seeing a huge increase in the number of overdoses of these medicines.

I appreciate your efforts to bring the VA online with our State-run prescription drug abuse monitoring programs. Now 48 States have those systems in place, and you have now linked up VA with those monitoring programs, which I think is a huge step forward. I am told that currently, one in six vets returning from war zones report symptoms of PTSD, one in six. I am sure you share my fear that as these wars wind down and our men come home, men and women, we could be faced with a very serious problem even beyond what we have today.

SCREENING FOR SUBSTANCE ABUSE

A 2012 Institute of Medicine report prepared for DOD recommended that we better prepare our military health providers to recognize and screen for substance abuse problems. Do you think that additional education for our doctors, nurses about the risks of these prescription pain killers would be helpful, or have we gone there already?

Secretary SHINSEKI. Mr. Chairman, I am going to call on Dr. Petzel here in a minute. Let me just summarize.

What you are describing here is an issue that concerns all of us, and I would say that in VA we have asked ourselves the question about overmedication. But again, all that we talked about, an integrated electronic health record that allows us to see what is happening in DOD as people transition out, a mandatory transition assistance program where everyone leaving the military has an opportunity to have an exit physical exam so that when they come to us, they come to us because we know there are issues to be dealt with. As opposed to discovering when someone is in crisis that overmedication or substance abuse is an issue.

The law precluded us from being able to do State monitoring before the chairman's leadership here, and with the law we are now able to participate. Regulation is in place, and we are in the process of executing what we have described as the right outcome.

With that, let me call on Dr. Petzel.

Dr. PETZEL. Thank you, Mr. Secretary.

STATE MONITORING

Mr. Chairman, I also want to add my thanks for the legislation that allowed us to do state monitoring. This is an important step in getting control of the issue of the overuse of opioids, particularly

by the veteran community, and avoiding the social consequences and the physical consequences of that kind of addiction.

Let me tell you what we are doing in addition to that. In terms of the treatment of pain, we have a stepwise pain program that begins with the least harmful, the least risky type therapy that includes acupuncture, et cetera, and opioids are at the very end of that stepwise process. We have educated everyone in our medical centers on this, and are working to educate our primary care providers, particularly in our community-based outpatient clinics, which is where much of this problem exists.

DATA SET

The second thing is that we have developed a data set that identifies veterans who overuse opioids, and prescribers who overprescribe or are outliers in terms of prescribing. That information is fed back to each medical center. There is an individual who is identified as being responsible for following up on each one of those outliers, be it a patient or a provider, to see that the issue is addressed with the individual provider.

I would say that there is never enough education about these things, so can we do more in terms of education? Absolutely, we can.

Secretary SHINSEKI. Mr. Chairman, just in closing, I would just say that veterans enrolled with or enrolling with VA are all surveyed when they come in for their visits, and they are interviewed about alcohol use, interviewed about substance abuse, about insomnia, about pain and pain management, all of this to identify whether or not there is someone in need of help.

Mr. ROGERS. Well, we had the problem in the private sector outside the military, particularly in my district where OxyContin became the killer drug. It is a wonderful drug for severe pain, 12-hour release, but when young people learned they could crush the pill and shoot it up and get that 12 hours in a split second, it was an immediate high and extremely addictive.

We now have required all opioids to have an abuse-deterrent feature, meaning that you can't crush it. It is a gummy thing that you can't abuse. However, a lot of our doctors, not knowing the dangers of OxyContin, began to prescribe them for a toe ache or what have you, and we became hooked, and we lost thousands of our young people, particularly in my district, and it was not isolated to the civilian sector. There were a lot of military people, veterans especially.

So this is something that is deadly. I think it feeds the suicide increase rate that we see in the military and with veterans. It is related, of course, to PTSD, and I think that our veterans are particularly susceptible to overprescription, and I would urge you to continue your strong vigilance on the problem because it is not going away.

Secretary SHINSEKI. Sure.

Mr. ROGERS. Thank you, Mr. Chairman.

Mr. CULBERSON. Thank you, Mr. Chairman. We expect votes about 11:45. Ms. Lowey.

Mrs. LOWEY. Thank you very much. Secretary Shinseki, I think you have heard our concerns. Frankly, to me, as a citizen, putting

aside my role as a Congresswoman, it is extraordinary that a four-star general and the Secretary of Defense could go with such distinction and protect our country, but as you said, for 4 years, there have been ongoing discussions and we still haven't worked out a seamless transition.

So I do hope that Secretary Hagel could match your efforts over at the VA and do what he has to do and get this seamless transition, whether it is the same VistA program or another one. So I just wish you good luck.

PRIVATIZATION ISSUES

And I want to say, Mr. Chairman, I do have some concerns about the privatization issue. I understand the desperation among my colleagues, but it is my understanding that 52 percent of the claims processors are veterans. And it would also seem to me that analyzing the situation, it is not the fault of the claim processors, it is the people at the top who can't seem to coordinate and get this system in place. And that would be my concern about even considering private sector contracts. I want to move to a related issue, which is jobs. The unemployment rate for younger veterans ages 18 to 24 has been the highest among all demographics. The projected drawdown in Afghanistan is likely going to exacerbate the situation for our younger veterans. If you could share with us what courses of action you are taking to tackle this particular issue, and also discuss how the $104 million for Transition: GPS, Goals, Plans, Success, will help separating servicemembers better prepare for their civilian life as they transition. If you could discuss the transition, what we are doing to improve this situation, that is another area that I think is so unconscionable.

UNEMPLOYMENT FOR VETERANS

I have several friends in the private sector who are aggressively working on this, getting corporations to hire veterans. But there should be a seamless transition. It should start before they become a veteran, before they are separated from the service. Can you talk about that, please?

Secretary SHINSEKI. Certainly, Congresswoman. We are all focused on the issues of unemployment for veterans at large. For one thing, we hire veterans. One-third of VA are veterans, fully one-third. And we have a goal of moving to 40 percent. Whenever we are in discussion with other agency and Department partners, hiring veterans is a discussion as well. We have partnered with the Joining Forces initiative that is led out of the White House by the First Lady and Dr. Biden. Their efforts have been to link in with the private sector and get corporations to provide jobs. The goal was 100,000 jobs for service spouses and veterans by the end of 2013. That goal was met in 2012. And my understanding is those corporations have committed now to increasing to 250,000 jobs.

HIRING FAIRS

So a lot of momentum there. In VA we conduct hiring fairs. We partner with the Chamber of Commerce. The Chamber's Hiring Our Heroes campaign has conducted in excess of 400 hiring fairs

around the country. We on our own, besides partnering with the Chamber, have put on three fairs with over one hiring fair a year. Ours is a little more deliberate. When a veteran shows up, we put them through a resume preparation program, which is automated. They describe what they did in the military, and it churns out, in business language, a resume. They get to edit it, and then we run it through the system, and they have their own resume to be used for whatever interviews they conduct later. On-site we also have seasoned interviewers who have interviewed for hiring. The veterans go through a training program, a process to rehearse what an interview is about. What does the interviewer want? What do you want out of the interview? They get to go through that training as many times as they want. Then they go onto the floor, where the real job interviews are, and they go for on the record.

They go to interview one, and if they are not satisfied they did as best as they could, they can go back to the training process. All of it intended for them to leave that day with a job, if that is possible. We have employers on-site. But more importantly, they leave with a resume and skills to be able to do interviews on their own.

Mrs. LOWEY. Thank you, Mr. Chairman. Thank you Mr. Secretary and good luck.

Mr. CULBERSON. Thank you, Ms. Lowey. Judge Carter.

Mr. CARTER. Thank you, Mr. Chairman. Mr. Secretary Shinseki, General, thank you for being here. Thank you all of you for what you do for our veterans. We are frustrated, and we are talking about frustrations that are significant to me. I came to Congress in 2002. When I came to Congress, there were certain things that we were demanding needed to be fixed immediately with the military. And the number one was the two health plans being able to function as one while communicating together. And it was always said VA had the good one, DOD had a bad one, we had to fix them.

I have been in Congress 10 years. I have heard exactly the same conversation today that I heard 10 years ago, with variations. That is very frustrating. Secondly, you are talking about having a third of the people in your agency are veterans. One of the things that has been a great joy in my life is to get to know the American soldier. And when I say soldier, I mean warrior. But my reference is Fort Hood, although we have Air Force contingency at Fort Hood also. And one of the things that is a sense of pride for all Americans is how well we have instilled in our soldier, in our warrior, how the mission is all important, and every soldier has a part of that mission, and that we leave none of our warriors behind no matter what. And American soldiers die every day meeting that obligation.

One of the frustrating things, General, that bothers me a lot, and I know it does you too, is we have veterans today that think the Veterans Administration is leaving them behind. They are being left on that battlefield. And they are so proud. Talk to veterans groups at home and they tell you that we have still got—the military still cares about us. And they are proud of having a veterans department that is theirs. Theirs. That is why you don't get veterans talking about give me a voucher to go to some other hospital. No. I want to be with my guys. That is their whole world.

When we fail those veterans and they felt like they are left on the battlefield, we destroy something that is very important to our country and we have instilled in these people. That concerns me as much as anything we are doing here, is that the average soldier—and I hear it from a lot of veterans today, a whole lot—that almost with tears in their eyes, I don't think I am ever going to get this claim finished. I don't think I am ever going to get my life settled. I go and I bang my head against a stone wall and nothing happens. I know the frustration. I am not military trained. I wish I had been. But I want to tell you, one of the things that you as a general know, most of these people may be ex-military, is when you plan to complete a mission, whether it be a small engagement or a very large scale engagement, you start with certain assumptions of things that need to be accomplished, you get as much intelligence on how to accomplish it as you can, then the commander instills in those below him what the ultimate objective is so you know we are all on the same team, we are going to take that hill, we are going to do this, whatever it takes, whatever the project is. As you proceed, you run into things that don't fit what you thought was there. There is always that outside influence, that outside thing that makes change. And what the Army and the military does so well for our soldiers is we train them to adjust, keeping their eye on the mission. You know this. I am not teaching you anything, you teach it. I know you have.

I think the VA has got so much of a relationship with the veterans, that is the way they have got to get this thing fixed, all these things fixed. It is like you take a functioning mission-accomplishing operation and you turn them into bureaucrats, which is let me sit and take care of my little niche and let the rest of the world pass me by. I don't know the solution. I think you do. I have great confidence in you as a leader. I have told you that more than once since we have met, because I knew your reputation from Fort Hood, which is you are very highly respected at Fort Hood. And I never hear a bad word about you. Everybody says he is a great general, he is a great man.

And I carry that with me. But somehow the VA has got to start performing its missions, and we have got to do what we are talking about here today. And it is a shame that an Army that can show the world, a military that can show the world that they can accomplish whatever mission they can do, we take them out and put them in their organization and we fail in our missions.

I will tell you I am embarrassed that the great place, which you know what I am talking about, Fort Hood, we call it the great place, has the worst VA record in the country. I am speaking of Waco, they are number one in backlog, at least they were unless you all have fixed it, and I would be very blessed to learn if you have. But we made the front page of the papers, the number one, worst VA facility in the country for backlog was the one that is related to Fort Hood. That is not acceptable for those of us who like to say that we produced a great place for warriors. And we want to have them have a great place when they go to the VA.

I personally will volunteer, if it will help, to chew butt once a month, okay, at the VA if you want me to. I personally will—I did this with the Highway Department Because I couldn't get them to

get off their butt, and I will do it with the VA. I am an old trial judge. I know how to do that pretty well.

And I will. We will have a meeting every day, we will see what has been done, and tell me why not, and what are you going to change to make it happen? That is not a question; that is a statement. I want to know why we haven't made those adjustments when we have run into these things. And how can we start making those adjustments and having trained people that say I see the goal, I see the mission, and I am going to do this mission? If I run into a snag, I am stepping over here and going past it.

Secretary SHINSEKI. May I just give a response?

Mr. CARTER. Yes, sir, please.

Secretary SHINSEKI. I would say there is no daylight between us, Congressman. I mean, we want the same things. And what you describe is my experience in uniform. Part of the culture change in VA is having the opportunity to be able to put some of those disciplines and behaviors in place. When I talk about training our workforce, it is very much at being able to hold people accountable. If you never train them to the standard, it is hard to hold them accountable because they have no way of getting there. So first a requirement is to establish a standard and train those folks to it. That is underway, and has been underway for some time. The other is to provide them the tools they have never had. This VBMS automation tool is powerful. And it is going to change the way we process claims.

Why do I know this? Because in 2009, when I arrived, Congress gifted our veterans with something called the 9/11 GI Bill. We didn't have a tool for that either. Congress said—I arrived in January, in August the program begins. I think you recall that first semester was pretty tough. It was all done by paper and pencil because we didn't have a tool. Well, that is what is going on in the disability claims program. At the same time we were doing paper and pencil enrollments, we began developing an automation tool for the 9/11 GI Bill. That fall semester, we struggled to get 173,000 youngsters enrolled.

Today, we have over 900,000 enrolled because of this automation tool we developed. We learned a lot going through that process. That learning translates into how we are fielding and developing this Veterans Benefits Management System, VBMS, that we have created for our disability claims processing. Same approach, to be incremental, and make sure it works, take the next piece, make sure it works, take the next piece. It sounds like a long and drawn-out process because it is incremental, rather than taking a big bite and have something fail and you don't know what caused it. This way we get to see what the issues are, fix them, and then keep moving on. In the long run, it is faster to do it that way.

I would say 6 months into it, we are at 36 of 56 regional offices. We will be completed with fielding VBMS, and then we will have a way of measuring improved performance. Waco had a good performance record. And so when we made the decision on Agent Orange, it was one of the places that we went to and asked them to do extra work. We saddled it with an additional workload that other regional offices did not receive. Frankly, we had to work through it. It took us 2 years to get all those Agent Orange claims

through the system. Some of their claims aged as well. We understood that was going to happen, and we are now in the process of bringing everyone back online.

Mr. CARTER. Well, thank you. And I have absolute confidence in you, Mr. Secretary, because I know your track record. I hope that you will help instill this in the workers at the VA—and I go out there two, three times a year, and they are great, great people. But let's don't let our soldiers lose their warrior ethos, their belief that our country cares about them, and will always get them off that battlefield alive. And if not, if they are not allowed, their body will go home, and won't be left on the battlefield. It means an awful lot to the future of this country that we keep that going. And I don't want us to be the cause—our VA to be the cause of them losing that faith in us. God bless you. I will help. You let me know. I will help.

Secretary SHINSEKI. I will. That very much resonates with me, Congressman. And let me just say this budget, just to demonstrate the amount of energy we are putting into it, this budget is about Veterans Benefits Administration, we have increased their budget by 13.6 percent, and it is about the IT tools that enable them to have those soldiers perform the way you and I recognize. A 10.8 percent increase to information technology in this budget. That is what we need to get to 2015. And without that, we would be challenged.

Mr. CARTER. Thank you.

Mr. CULBERSON. Thank you, Judge. Mr. Secretary, I am of course, struck with the judge's comments. I couldn't agree with them more. And the VA's customers are our veterans who have served the country. And I always am struck when I visit, if you think about it just very quickly before I recognize Mr. Farr, and they just started on a series of six votes, and obviously we will come back after the end of those votes because members have a lot of questions, and we appreciate your patience. There will be a six votes, with a motion to recommit in the middle. So it is going to be an extended series of votes.

CUSTOMER SERVICE

Just very, very quickly, while the members are here, and I would like for you to think about it and I think all the members here, when we visit at home with successful businesses in our districts, talk to the CEOs, the senior executives in those companies are always focused on the customer. They always talk to us about what they are doing to meet the needs of their customers. And you never hear any discussion about what they are doing in the top office, or what they are doing in management, or that they have got more money thrown at different sectors of the company. All you hear about is the customer. And I have to say in 3 years I have had the privilege of severing on this subcommittee I rarely ever hear any discussion of the customer from the VA's top leadership.

And I think that may be one of the—I mean, obviously you are concerned about it. But I mean if I just could encourage you just shift your mind-set so you are looking at the VA—the military works from the top down, the VA ought to work from the bottom up. And just think about everything that you do in terms of the in-

dividual customer, the individual veteran, and what you can do to make sure that, as Judge Carter has said, that they don't feel left behind. I think it would help a lot. It certainly helps in the private sector to stay focused on the customer, and it would help the VA to stay focused on the customer.

Secretary SHINSEKI. May I respond?

Mr. CULBERSON. Yes, sir.

Secretary SHINSEKI. I would say I appreciate those comments. And if in 4 years you have not heard me mention veterans——

MIND-SET OF THE AGENCY

Mr. CULBERSON. Oh, no, I have heard you mention them. But I just think in terms of mind-set, sir. No, of course I know you are committed. It is not my intent to demean that. I just think in terms of mind-set of the agency as a whole, the mind-set of the private sector is always focused on the customer and how can we meet their needs. And you just don't see that, as I think you should, particularly at the VA.

Secretary SHINSEKI. I would say that is our only mission, Mr. Chairman. I mean if you look at any of our buildings, emblazoned on them is the words of Abraham Lincoln, to care for him who have borne the battle.

Mr. CULBERSON. Certainly. I know of your commitment, sir. It is just that there really is a different mind-set when you listen to the private sector focused on customers with the Federal Government. I appreciate all that you do. I recognize Mr. Farr. And we will, of course, come back. Let's go until about 5 minutes left in the vote, and then we will recess and come back after the votes. Thank you.

Mr. FARR. Well, first of all, I have to say that my constituents complain a lot more about banks than they do about Department of Veterans Affairs. And they think they get a much better treatment. People respond when they ask questions at the Department of Veterans Affairs, and they don't when their house is being foreclosed on and their mortgages are upside down and they can't qualify for other loans.

So I think if the private sector is the chairman's example that pays attention to customers, it certainly is not in the financial services industry. And I want to personally compliment you. I don't think any Secretary has done a better job. I mean you, not only as you told about initiating the GI bill, but you have been the first Secretary to really focus on how to eliminate homelessness of veterans. And that was one of the pledges of this committee many years ago, that we were going to leave no vet behind, and we were going to try get the Department to really drill down and do work with the homeless. And you have led the effort on that. You have expanded the disability category. No wonder we have so many files. I mean, I am as upset as everybody else about the backlog. But remember, we also gave so many more opportunities for veterans to file. You opened up the disability claims, and you now have veterans filing with five, six, seven more claims per filing issues than previous veterans did.

I can understand what created this incredible rush and backlog. And hopefully we will, with your leadership and the money that we appropriate, be able to make progress on servicing these claims. I

also think the Department of Defense should put some money into it because they are the ones that cause the problems. And I am furious at the fact that they can walk away from a lot of the responsibilities, including paying for making plans work and health care plans being interchangeable. Having said that, I have been really drilling down lately just trying to work out the local and State Veterans Affairs offices. And I realize that what is happening in our States is they take for granted all the money that goes to the States for veterans. And you give these administrative moneys to them, it never gets the kind of scrutiny that it does here because it is not a State responsibility, they are not paying for it out of State tax dollars or local tax dollars. And so the review, when we were in the legislature and we were in local government, is, oh, that is a Federal program that just happens to be housed in our county. And let's move onto something where we really have some authorities and some money in the game. And I think that you need to use your carrots with these States and local governments to shape them up to be as competent as you would like to see in your own department. Because I think there is a lot of incompetency and a lot of misinformation in State and local veterans departments.

STATE-FUNDED CEMETERIES

The other thing that I am concerned about is, as we have in California, is that the State doesn't want to pick up the responsibility for a State-funded cemetery. You and I have discussed this many times. And I would just like to refresh the Committee's memory: In fiscal year 2013 CR, we had language in there requiring the National Cemetery Administration to submit a strategy report to the committee on how the VA plans to meet its burial needs for veterans in rural areas. I mean, we do have a lot of veterans clinics and veterans hospitals, but sometimes they are so far away that the veteran can't take advantage of them. Cemeteries are similar. And what this report was supposed to do is to include a time frame for implementation of five new burial sites in rural locations. And I just wondered what the status of that report is.

I am also interested in whether that report has included Fort Ord, which is still in Federal hands. I also would like to urge you again, with staff, to review this internal policy of requiring that anything within a 75-mile radius, if there is space available you can't expand. I mean, you essentially waived that 75-mile radius when you proposed creating the urban columbarium program in fiscal year 2011. That program, created without congressional approval, would allow veterans in urban areas, even though they have access to cemeteries within a 75-mile radius, to create new columbariums.

And that has caused a lot of problems because people are thinking, well, if they can do it in the San Francisco Bay area, why can't we do it down in our area? The rule also doesn't consider actual drive time, or driving distances. It is just as the crow flies. And there is certainly differences in different parts of the country as to how difficult that 75-mile guideline has been.

So I would really ask you to look at that and revise that definition to reflect more the practicality of being able to get there.

We are trying to put it all together to try to get a State cemetery in California by having the locals raise money. Our veterans have had to go out and do bake sales, they have had golf tournaments. The State wants about $10 million raised out of it. The locals are not going to make it. And it is just tragic that, if we are going to have this program, that we don't use a little bit more of your stick, carrot and stick to make these States step up to the plate and take the responsibilities. We spend about $10 billion in veterans benefits in the State of California. Ten billion. I mean that is a huge part of our economy. And we never get thanks for it. And I want to thank you for being in charge. And I want you to use your general leadership to shape up the troops out there, shape up my State and local government troops.

Secretary SHINSEKI. Congressman, let me ask Secretary Muro to respond to the specifics of your question regarding rural burial policy. I look forward to continuing to work with you on trying to meet the requirements for a solution here that serves veterans in Monterey.

Mr. FARR. I would be remiss also if I didn't ask you, on behalf of the Northern California Members of Congress, bicameral, we would love to have you come visit the Oakland office, which has the largest backlog in the country. Really, I think your leadership and presence there would make a big difference.

Secretary SHINSEKI. Okay. Fair enough. Mr. Muro.

Mr. MURO. Thank you, Secretary, thank you, Congressman Farr, for that question. Let me start off by saying I have the privilege to lead the National Cemetery Administration, the only organization to ever receive a 95 score for customer service, not only in the Federal Government but also in the private sector. So we do address our customers, and we do work with our veterans to ensure they get what they need in the burial benefits and other benefits that they have earned.

We did provide a reply to the rural policy. We submitted the policy. The urban policy was also approved by the Congress in the fiscal year 2011 budget. So we have those two new policies approved. The rural policy is looking at states where we have no VA national cemetery service and a population of 25,000 or less veterans that live in those areas within the State. But we are working closely with the States, so they continue to build State cemeteries and we don't overlap in their service areas. In California, Congressman, as you know, we have worked closely recently with your staff and with the staff of the State of California. They are actually revising their plan because they realize they submitted too high of a cost.

Mr. FARR. I am familiar with that.

Mr. MURO. And between your staff and my staff, we were able to convince them to submit a better plan that is more realistic so that they can get funded in our State grants program.

Mr. CULBERSON. Mr. Farr, if I could, members that could not come back—are you able to come back, Sam, afterwards, after votes?

Mr. FARR. I don't think so.

Mr. CULBERSON. Okay.

GETTING LOCAL GOVERNMENT TO STEP UP

Mr. FARR. I know you want to end this. States that are interested in building State cemeteries can, and that was California's problem, that they didn't want to. They left it up to us to devise another method. We have tried to get the local government to step in for the State. And so it has been kind of a mess, because the locals didn't know how much money they had to put up. We need you to use your authorities, if you are going to go out and get these States, and even California. Use your muscle, and say, look at how much we are putting into this State. You got to shape up and be much more responsible in helping them. The States never did anything to implement it. They just stood back and watched. Now I have beaten the hell out of them, and they are paying some attention.

Mr. MURO. We appreciate your support. I know that the Secretary sent the Governor a letter, encouraging him to build a State cemetery in Monterey. So we are working closely with them.

Secretary SHINSEKI. Congressman, I will pick up on that.

Mr. FARR. This should have been the Feds that built it.

Mr. CULBERSON. Thank you, Mr. Secretary. Mr. Rooney.

Mr. ROONEY. Thank you, Mr. Chairman. I know our time is very limited. I just wanted to echo a lot of what has already been said. General, I might be the only one that serves on this committee that actually served under you when you were the chief of staff and I was a young, much skinnier captain down at Fort Hood. So it is an honor to be here getting a chance to address you as a Member of Congress.

You know, one of the hardest parts of my job, and I represent south central Florida and St. Petersburg regional office, I was told had the sad distinction of being one of the largest backlogs in the whole country. And one of the hardest parts of my job, and I am sure everybody else here, is when we get these constituent service issues that come into our district offices and it deals with, you know, my backlog, my claim, it has been so long, and we are making excuses almost for you of why things are taking so long. And you sort of run out of answers. And when we are trying to work together, it just gets very frustrating. And I think that you have heard a lot of that up here today. I certainly have a lot of retirees in South Florida.

So a lot of my questions don't deal with banks, they deal with the VA. I am encouraged by a lot of the things I have heard up here today with regard to the integrated computer system. We came into government together as far as up here. I came in in 2008 as well. And I heard you testify in the Veterans Committee about doing this then. So I mean the time to move forward, hopefully 2015 is realistic, and I know that you have added on a lot of things, but I would disagree with one thing that you said, and then I am going to yield, is you said that there is sort of a separation between DOD and the VA when it comes to their lane of providing national security, and yours as taking care of the people after they get out.

DOD-VA CORRELATION

I think there is a correlation. I think that people will see certainly if we are not doing what George Washington said, taking care of the people that serve our country as a reflection of who we are as a Nation, then why the hell would they join the military if they are going to see that once they get out they are not going to be taken care of?

So, again, it has been an honor to serve under you, sir, and, you know, I am rooting for you. And but we have had to make a lot of excuses to our constituents that is just getting very cumbersome. I don't know why DOD and the VA doesn't do one single computer system, as Mr. Bishop said, from enlistment until death. I don't get that. But anyway, thank you very much. I don't have a question. I am going to yield to Mr. Fortenberry.

HIRING OUR HEROES PROGRAM

Mr. FORTENBERRY. Mr. Secretary, pleasure to see you, and thank you all for coming today. And I regret our time is so compressed. So I am going to throw out a few points for your consideration, and you might not have time to respond. First of all, Hiring Our Heroes. Thank you for partnering that. This is very important. It is an absolute scandal that there is an 11 percent unemployment rate among veterans, perhaps higher given that the national average is perhaps 8 percent or higher. We had a very successful event back in my district in Nebraska. The willingness of the private sector to partner to look for people with leadership and technical skills that are coming out of the military I think is something that we must continue to unpack and expand and promote. Good program. So thank you for working on that.

CONSTRUCTION BACKLOGS

I have a question regarding the current capacity of our system. If we are at a high water mark in terms of the number of veterans coming through, what those projections look like over time. And that, of course, begs questions about future capacity and shifts of capacity. Related to that, in Omaha we have got a VA Hospital where the operation room is closed because it is potentially dangerous because of the shabby condition of it. The new hospital in Omaha is at least 10, perhaps 15 or maybe more years away in terms of construction. You have got a lot of projects ahead of that, many of which are concentrated in California. It would be helpful for us to continue to understand, you know, how we move forward in a more aggressive way to get a facility that makes sense there. I have a related question regarding how the VA is beginning to look creatively at partnering with other institutions to carry on the important legacy of targeted services in the medical sphere for veterans, exclusively for veterans, but perhaps in full partnership with other institutions that could actually help you deliver effective services and save money. Thank you, Mr. Chairman.

Mr. CULBERSON. The vote is closed. So we will recess. I think there will be a couple of members coming back to ask additional questions. Thank you very much. The committee will stand in recess. Thank you.

[Recess.]

Mr. CULBERSON. The Committee will come to order. We want to thank each of you for your patience while we went to that series of votes. And the chair recognizes at this time my good friend from Mississippi, Mr. Nunnelee.

Mr. NUNNELEE. Thank you, Mr. Chairman. Mr. Secretary, I really do appreciate your staying around to be able to address some very important issues. Sonny Montgomery was a man who served honorably in this body, and dedicated his entire career to making sure that veterans had the benefits and care that they had earned. We have a hospital in Mississippi that bears his name.

In March, the Office of the Special Counsel, whose responsibility is to handle complaints from whistleblowers, issued a report. And I will just quote from that report. Ms. Carolyn Lerner says that, "Collectively, these disclosures raise questions about the inability of this facility to care for veterans and its services." And I understand that investigations are still underway. We may be moving in the right direction, but we have a long, long way to go.

SPECIAL COUNSEL'S INVESTIGATION

Our veterans deserve the best medical services. And I am not really sure why we have these same problems year in and year out. I will give you a chance to respond to the overall issues raised in that report, but I would also like you to respond specifically. Can somebody give me an update on the Special Counsel's investigation on the failure of the VA radiologists to properly read or even read at all thousands of x-rays and MRIs? And have the affected patients been contacted?

Secretary SHINSEKI. Congressman, let me call on Dr. Petzel to provide a response here.

Dr. PETZEL. Thank you, Mr. Secretary. Congressman Nunnelee, to respond directly and specifically to the issue of radiology, this is a three-year-old item that has been investigated by the VA and by the Inspector General on three different occasions, and have verified the fact there was really, in essence, no patient harm. The Special Counsel has asked us to take another look at it. And we are having another external review of the radiographs that were called into question. But to speak a little bit more broadly about Jackson, we obviously are committed to providing the very best care we can for America's veterans, and ensuring that that care meets the highest standards of quality.

The VA has a national reputation for the quality and safety of its programs. The issues that have been raised there by the Special Counsel, there were five of them, three have been closed, two are in the very end stages of investigation and being closed. New management there I think has addressed the problems that existed. And the hospital is now a very, very good hospital. Its quality scores over the last year are excellent. It has been reviewed by 48 external agencies and groups in the last 18 months, all of which have given it a very clean bill of health, including the Joint Commission. This is a good hospital.

Mr. NUNNELEE. So as a follow-up, you say there was no patient harm. Is it the VA's contention that these allegations that these x-rays and MRIs that were alleged were not read were in fact read?

Or are you saying that they were not read and there was no patient harm in the fact that these were not properly read?

Dr. PETZEL. Congressman, there were x-rays that were not read, or maybe not read properly. What I am saying is that as a result of that, there was no patient harm.

Mr. NUNNELEE. Now I am really confused. If I am a patient and my x-rays are not read, how can there be no harm?

Dr. PETZEL. It may have been a routine chest x-ray. First of all, let me make it clear, we don't want anybody's x-rays to not be read in a timely fashion. And that is not the case at the Jackson VA any longer. But if it is a routine chest x-ray and it is not read, or it is read a week or two weeks later, that is not going to harm the patient.

Mr. NUNNELEE. Is that the same expectation that you would have in a civilian hospital, that you have routine x-rays that are never read?

Dr. PETZEL. Oh, absolutely not. As I just said prior to that statement, that we expect the x-rays to be read the same day in a timely fashion, absolutely. And that is the standard that Jackson is performing at right now.

Mr. NUNNELEE. But there is no patient harm if the x-rays were not read?

Dr. PETZEL. The example I gave, I think, Congressman Nunnelee, stands.

VETERANS ADMINISTRATION'S IG REPORT

Mr. NUNNELEE. All right. Let me move onto a second report. The Veterans Administration Office of the Inspector General issued another report with several areas of deficiencies, including deficiencies in cleanliness, medications not having proper labels, et cetera. What is being done in that—in the area to address that report?

Dr. PETZEL. Congressman Nunnelee, could you give me a little bit more specifics about what that investigation was?

Mr. NUNNELEE. All right. I have in front of me, the Veterans Affairs Office of the Inspector General report dated February 17, 2013. Eight evaluations. It says five were not reported in a timely manner. In addition, for all 12 months the standard of continuing care stay reviews was not met. In addition, regarding the facilities' ability to maintain a clean and safe health care environment, the Office of the Inspector General had several findings, including two of nine areas that were inspected that were not clean, and in four units medication bottles did not have the proper labeling or expiration dates.

Dr. PETZEL. Congressman, I understand now. You are talking about the comprehensive three-year review that the Inspector General does, we call it the CAP review. That was actually a very good CAP review report. There were some findings. There were fewer findings than we see on average in a CAP review around the country. And the organization, the medical center, now has in place a solution to fixing each one of those individual recommendations. We rely on the CAP reviews to help us ensure that we are doing the high quality care that we expect to do and that our veterans deserve. And we take those recommendations that they come up

with very seriously. But this was, in essence, a good CAP review for the Jackson Medical Center. It is one of the external reviews that I referred to earlier.

OBTAINING ACCESS TO SPECIALISTS

Mr. NUNNELEE. All right. And Mr. Secretary, I have got a more general question. I continue to hear from veterans that I represent that have great difficulty in obtaining access to specialists, as opposed to general care. And I still haven't figured out why that is occurring. Are you aware of other problems around the Nation with access to specialty medical care?

Secretary SHINSEKI. Congressman, I would say that if you were to look back over the past 4 years, a tremendous investment on our part is to provide tele-health, telemedicine connection for wherever a veteran enters our health care system, and there is not a specialist located at that facility. There is always a need, even with the number of specialists we have, we don't have them in each outpatient clinic. Wherever they enter, they can have access to that distant location where the specialist may be located.

This year we are investing another $460 million to make this vibrant connection between our hospitals, our community-based outpatient clinics that are located in communities where veterans live, 300 or so vet centers, and probably 80 mobile vans that travel to the most remote areas. All of this is connected by tele-health, telemedicine hookups to address the problem that you brought up. As I say, a veteran, no matter where he or she lives, deserves to have access to the best health care we have in our system, whether they are in a remote rural area or in the suburbs of Washington, DC. That is my personal goal.

Mr. NUNNELEE. Well, thank you. And as has been articulated by other members of this subcommittee, I look forward to working with you to make sure that the men and women who have defended freedom get every bit of the benefits in health care that they have earned. Thank you.

Secretary SHINSEKI. Thank you, Congressman.

Mr. CULBERSON. Thank you very much, Mr. Nunnelee. Mr. Fattah.

Mr. FATTAH. Thank you, Mr. Chairman. First of all, I think that the work that you have done has been extraordinary given the challenges that the VA faced when you walked in the door. After having an entirely paper-based system, the fact that you are now processing over a million claims a year. There is every reason for us to believe that you are going to be able to achieve your goals by 2015.

So I want to thank you not only for your previous service, which has always been heralded, but also your current service leading the VA. The chairman and I work together on another subcommittee, and we created a neuroscience collaboration among a number of agencies that has been in place for the last year. The VA has been one of the leading participants looking at a whole set of initiatives around what we can do about hundreds of brain diseases and disorders. And I want to thank the chairman publicly for his help. There is always this notion around here that we don't act in bipartisan ways. And it is actually not the truth. We get a lot done.

EPILEPSY CENTERS AND TRAUMATIC BRAIN INJURIES

This is an initiative that I have talked to you about over breakfast. In addition to your work with the Epilepsy Centers for Excellence and the other work on TBI, traumatic brain injuries, there are in your budget a number of important areas that we want to continue to make sure receive the appropriate level of support. I think that the public is not aware that a large percentage of our returning veterans who have been injured have also suffered brain injuries. I was at the Intrepid Center, looking at some of the work being done there. If you could make some comments on the record about this particular area of work. Because it has applications not just inside the VA for the veterans you are serving, but also for the general public.

Because as you know, there are 1.8 million traumatic brain injuries in the civilian population, young people a lot of times who are engaged in a lot of activities end up being injured. So a lot of what you have learned is applicable over on the civilian side too. So thank you for your testimony today. I would be glad to hear your response.

Secretary SHINSEKI. Congressman, I am going to call on Dr. Petzel here to provide some detail specifically about the research on the brain. I would just say overall, we are requesting for this year, $586 million in 2014 for research projects. We have probably, in priority, about 2,200 projects that we have identified we want to work on. Things we go after are the unique needs of veterans. That usually refers to PTSD and traumatic brain injury.

Also pain and prosthetics, with focus on veterans coming out of the current conflicts, Iraq and Afghanistan. What we learn there in prosthetics applies to vast generations. Also homelessness and women veterans research. We know that in VA we are about 6 percent women veterans today. In the active force, it is 15 percent. We know there is a flow of veterans coming to us. We don't have a lot of background and research on women's health issues. We need to be out ahead of this. So that is another priority. Let me ask Dr. Petzel specifically to address the brain research.

Mr. FATTAH. Thank you.

Dr. PETZEL. Thank you, Mr. Secretary. Congressman Fattah, I want to thank you and the Chairman for your interest and your energy around the brain sciences and the research efforts around brain sciences. This is an effort that is certainly going to very directly affect the health and the well-being of America's veterans, for reasons such as you cited earlier, including the number of people that are returning with brain injuries of some kind.

There are 50,000 people who have been evaluated for mild to moderate traumatic brain injury; 34,000 veterans have been positive. So this is really going to have an impact on our community. And we appreciate it. I will just tell you briefly how the VA is engaged in this effort. First of all, we have about $123 million worth of research that is being directed at mental health issues, many of which will have direct impact on the neuroscience research projects that are going on. DOD and the Department of Veterans Affairs are engaged in a joint effort, under the aegis of the President's executive order, to each commit $50,000 over 5 years to efforts to de-

velop research in PTSD and traumatic brain injury, specifically focusing on trying to develop biologic markers for those two illnesses. This will assist us in making the diagnosis, and to mark the progress in therapy with these veteran patients who have come back from war with these unseen injuries.

Mr. FATTAH. Thank you. And just to clean the record, you meant $50 million each.

Dr. PETZEL. I did. What did I say?

Mr. FATTAH. Fifty thousand.

Dr. PETZEL. Oh, yes, thank you. I appreciate that.

Mr. FATTAH. You know, my father was a veteran, and my father-in-law, and my brother served. The VA means so much to so many of our fellow citizens in terms of the range of its services. I have a young man in my office in Philadelphia who handles veterans affairs who served in multiple tours in Iraq and was injured in his last tour. Some 59 operations later he is healthy, and has got a better golf score than me. He just got married. He is going to have his first child, and is in graduate school. All of this because of the work that the VA is making possible in terms of his continued care. That represents a story that you could tell all over the country. And even as we talk about this backlog, I want to make sure that the record is clear that for each returning veteran, there is 5 years of health care. This is without having to do with the processing of their claims. So their health needs are being met immediately. Is that correct?

Secretary SHINSEKI. That is correct, Congressman.

Mr. FATTAH. So I want to thank the chairman and the ranking member for holding this hearing and dealing with this. There is no more important subject matter. And again, let me thank you publicly for you and Chairman Wolf, and your willingness to work with me on this neuroscience initiative, which I think is going to vastly improve our ability to address a whole host of challenges related to brain diseases and disorders. Thank you.

Mr. CULBERSON. It is tremendously important work that I am proud to work with you on. And it is also a pleasure to work with you in support of the sciences, the medical and scientific research that we both have a real passion for on that committee, the space program. We do. The press is not accurate, the public is of the impression we don't work together, and actually we do.

Mr. FATTAH. We have done some great work together, and it is going to be meaningful in millions of people's lives. So thank you.

Mr. CULBERSON. Absolutely. We do appreciate it. I also really appreciate Mr. Fattah bringing home a point that I can't reemphasize enough, and that is the tremendous successes, what a blessing you are for the lives of so many veterans and their families and the health care that you provide. I also hear almost nothing but glowing reports of the work that is done by the VA hospitals. We are all frustrated with the backlog of disability claims, but that is a separate issue. As Mr. Fattah said, it is from the health care that you provide as the veteran leaves the service and goes into a VA Hospital. The DeBakey facility that is in Houston, Texas, I hear just nothing but rave reviews and great work that is being done down there. I thank all of you in public, and to reiterate my good friend's quite appropriate comments. Because we are all so stirred

up about the disability claims, we neglected and should have focused on just saying thank you again, A, for all that you do, B, certainly for that health care service that you provide. And all the help that we can provide you to speed up the disability process.

SINGLE MEDICAL HEALTH RECORD

Thank you. I would like to, if I could, we are going to have to clear the committee room here shortly, but I did want follow up, if I could, Secretary Shinseki, and it would be very, very helpful I think for the record and for moving forward on the unified medical record. I wanted to ask you, sir, if you could definitively and clearly endorse for the record: do you believe it would be a good idea for there to be a common system chosen by both Departments, DOD and VA? And I would like you to just be very clear. And we hope you would endorse and support that idea. And if both Departments do not choose a common system, why shouldn't Congress insist that they do so?

Secretary SHINSEKI. I think Congress has registered their concerns and interests on this in prior hearings. And I think, Mr. Chairman, that is reflected in the actions of Secretary Gates and I, Secretary Panetta and I, and now about to enter into our discussions with Secretary Hagel. We have committed to a single joint common integrated electronic health record. We don't want to have two systems. We are working on how to put this in place. We have also committed, our two departments, in past discussions, to an initial operating capability in San Antonio and in the Tidewater region of Virginia with initial operating capability in 2014. There is an expectation that we are going to show some progress.

Mr. CULBERSON. And you share the opinion it would be far better, far more beneficial to veterans and better for the taxpayers that DOD and VA operate one system.

Secretary SHINSEKI. I agree with that.

Mr. CULBERSON. Are you aware of any technical reasons why one system could not be adapted to meet the needs of both Departments?

Secretary SHINSEKI. I am not aware of impediments. Are there opportunities to improve what we have? That will be ongoing, Mr. Chairman. When we in VA first fielded this electronic health record in 1997, it took us perhaps 7 years to get it fully up and running and integrated throughout our operations. It cost about $4 billion, but the return on investment has been $7 billion. Our health care quality has gone up, safety has gone up because physicians have access to a medical record that they had probably access on 60 percent of the time. Our vaccinations for veterans over 65 was trailing the country in 1997. Today we lead the country, well into the 90s. So it has a cost benefit, a health care benefit, and provides safety to veterans. I think this is all good news for what we are trying to accomplish here.

COST TO MODERNIZE VISTA ELECTRONIC HEALTH RECORDS

Mr. CULBERSON. How much, Mr. Secretary, do you anticipate it will cost to make the necessary modernizations to your VistA electronic health record? And now that you and the DOD have decided to go two different paths, your budget requests $344 million for the

electronic health record. Do you expect that number to change as DOD selects its own system?

Secretary SHINSEKI. I await a discussion with Secretary Hagel—since this is a joint project—on how these numbers will shake out, but our 2014 budget request accommodates what we expect is our need, and that is $344 million that will cover our requirements in 2014.

Mr. CULBERSON. Well, I know the Congress, all of us, feel very strongly we need a unified medical record and hope you will continue to pursue that, and we will certainly help you with it.

Let me ask a couple of quick questions for my good friend and colleague Bill Young, and then pass back to my good friend from Georgia.

Chairman Young has asked—he is not here today and regrets it very much because he is chairing a hearing of a subcommittee with the commanders of U.S. Central Command and our forces in Afghanistan; however, he did ask me if I could ask you to comment on three issues.

POINTS SYSTEM TO MEASURE PERFORMANCE

Chairman Young understands that the point system that is being used to measure the output of claims processes has resulted in some employees cherry-picking claims, going through the easy ones first because they can get more points for them. Chairman Young has asked for your thoughts on this system and how widely used the point system is within the VA system.

Secretary SHINSEKI. I am going to call on Secretary Hickey here to provide some detail.

I would just say, Mr. Chairman, that when we imposed the Agent Orange decision, it slowed things down, and so we are now trying to get the oldest claims moving. I think there is a good opportunity to do this. I don't profess to know everything that goes on in the claims processing business. I have not heard of the cherry-picking phrase, but let me just ask Secretary Hickey to comment.

Ms. HICKEY. Thank you, Chairman, for the question.

We do rely on a point system for doing claims and for production requirements for our staff; however, we have heavy engagement and oversight from our coaches, who are in supervisory positions within those smaller teams. They are engaged in actually making sure work is distributed in a fair and equitable way. We are also looking at, how we are moving into a new environment and where our productivity is increasing. We are now in our new segmented lanes across the board 9 months ahead of plan, in express, core, and special lanes of operation. We are also in conversations with our employees' representatives on what we can do around our point systems to increase productivity with our employees and to also focus heavily on quality.

Secretary SHINSEKI. If I could just add to that.

Mr. CULBERSON. Certainly.

Secretary SHINSEKI. One of the benefits of having an automation system is that, to the question you asked, we can now see individual performance by our claims adjudicators, and we can begin to focus in on what is going on. Right now with all that paper, it

is hard to see, and you get anecdotal reports, and then you go charge off to check. One of the benefits here of the automation system, which is what we want, is to be able to manage and be able to acknowledge where we have issues, and we have to go to work on.

PAPERLESS CLAIMS SYSTEM

Mr. CULBERSON. Chairman Young has also asked about the paperless claims system, and he is being told by constituents that are concerned that the system is actually slowing down the claims process. Could you comment on that, and also whether or not you have found it difficult to hire enough people? He is wondering is there a staffing problem within the VA disability system, Ms. Hickey, and if so, what are you doing to solve the problem?

So if you could answer those two about slowing down the paperless process, slowing down the claims process and staffing.

Secretary SHINSEKI. We are fielding a new system, and as you field, I do think you have a little degradation in the work efficiency. I mean, for those of us that have gotten a new computer with a new program on it or even changed our password, instead where the old password is, automatic—with a quick run of the fingers, the new password slows us down until we get into the rhythm of it.

I think the man-machine interface here is true. There is a little bit of degradation, but once you get through that period, and it is a short period, the power of the microprocessor gives you a much better return for that momentary loss of efficiency.

Let me turn to Secretary Hickey for the second part of the question.

Ms. HICKEY. Chairman, we are actually staffed at 101.4 percent of our authorization, and so we are fully staffed. Our attrition rate, frankly, in VBA is very low. In fact, the standard for all Federal Government is 17 percent. Right now our attrition is about 6 percent. We are hiring a lot of veterans. In fact, last year, fiscal year 2012, 82 percent of everyone we hired in our regional offices was a veteran. We are very focused on bringing veterans into the work environment and also into an environment where they continue to care for one another.

Mr. CULBERSON. That is marvelous. I deeply appreciate your service to the country.

Mr. Bishop, any further questions?

Mr. BISHOP. I will have some further questions for the record. We will submit them to the record.

Mr. BISHOP. Let me thank all of you for your attendance, Mr. Secretary, and we know that you have a very, very difficult challenge that you face in behalf of looking after those who have looked after us. You know that all too well. So we look forward to continuing to work with you to meet these challenges, but we cannot at all not hold ourselves, hold the Department accountable for taking care of the veterans, because they have sacrificed so much for the freedoms that we enjoy, and we want to make sure that we do right by them.

Mr. CULBERSON. Thank you very much. And I do want to reiterate Mr. Bishop's gratitude. We admire you deeply, appreciate so

very much your service to the country, and look forward to working with you to help you make sure that our veterans have the best health care in the country.

Secretary SHINSEKI. Thank you. Thank you, Mr. Chairman, to both you and the ranking member, for support over a number of years now, and I want to assure you, we are sighted on what is right, and that is to take care of this claims backlog. We have a plan. This year's budget looks for resources to allow us to do that. So thank you very much for your support.

Mr. CULBERSON. Thank you very much, sir, and the hearing is adjourned. Thank you.

[Questions for the record follow:]

[Questions for the Record submitted by Congressman Culberson for the Honorable Eric K. Shinseki follows:]

Veterans Benefits Administration

Question 1: Mr. Secretary, you indicate you use a point system to evaluate the performance of claim processors. Please identify the tasks for which points are awarded and the number of points that are scored for each task.

Answer: The Veterans Benefits Administration (VBA) holds employees at all levels of the organization accountable for performance as we continuously strive to fulfill our commitment to providing timely and accurate benefit decisions for our Nation's Veterans. Objective measures and performance standards are used to make basic determinations about whether our managers and employees are meeting or exceeding their job requirements.

Veterans Service Representatives (VSR) and Rating Veterans Service Representatives (RVSR) receive weighted credits for daily work actions completed. Employees are evaluated on their cumulative production. VSRs will receive weighted credit for actions that move claims through the development cycle, such as issuing a Veterans Claims Assistance Act notice or requesting Federal records. RVSRs receive credit for completing a rating decision. The credit is weighted depending on the number of medical issues decided.

In December 2012, VBA revised the performance standards. The new performance standards account for variance in different segmented lanes and ensure that work credits are assigned appropriately. VBA has also established a new team to work in conjunction with our workforce representatives to continue to develop standards that will better serve Veterans as we move into an electronic environment.

Question 2: Are any disability claims currently processed completely without paper?

Answer: Yes. The Veterans Online Application Direct Connect (VDC) allows the Veteran to submit an electronic compensation claim and supporting documents using eBenefits, a joint VA-Department of Defense (DoD) client-services portal for life-long engagement with Servicemembers, Veterans, and their families. Information and data from claims filed through eBenefits using VDC are loaded directly into the Veterans Benefits Management System (VBMS) for electronic processing at the regional office of jurisdiction.

Question 3: How many claims have been completed to date through VBMS and how many are projected to be processed through VBMS each month of fiscal year 2013?

Answer: The evolution of VBMS is occurring across four distinct phases or generations of development. Generation One of VBMS began in 2010 with the

conceptualization, piloting, development, and deployment of baseline system functionality with improved quality (required actions and automation) and efficiency (no paper). Generation One of VBMS concluded with the successful implementation of Release 4.1 in January 2013. This generation culminated in a foundational Web-based, electronic claims processing solution featuring:

- Integrated claims establishment, development, and rating capabilities;
- Basic baseline automation via features such as automated letter generation and data population; and
- Basic workflow and workload management capabilities.

As we move into Generation Two of VBMS, the focus is on building additional system capabilities while leveraging simple automation features and deploying the system to all remaining sites. Upcoming system releases include planned improvements to correspondence and work queue tools, additional rating calculator functionality, and more extensive data exchange and system integration capabilities. The most recent Release 4.2 was deployed to the field in April 2013.

National deployment of VBMS is underway, with 42 offices using VBMS as of the end of April 2013. Deployment to all 56 regional offices will be completed by December 2013.

VBA is building new decision-support tools to make our employees more efficient and their decisions more consistent and accurate. We have already developed rules-based calculators for disability claims decision-makers to provide suggested evaluations. For example, the hearing loss calculator automates decisions using objective audiology data and rules-based functionality to provide the decision-maker with a suggested decision.

Future generations of VBMS will focus on continuing to improve electronic claims processing by providing increased system functionality and more complex automation capabilities for all VBMS end-users.

From October 2012 through the end of April 2013, VBA has completed approximately 5,800 claims from start to finish in VBMS. However, the current inventory of nearly 800,000 paper-based claims are in various stages of development, and will therefore continue to be processed in paper. VBA expects to have approximately 30 percent of its total inventory in VBMS by the end of calendar year (CY) 2013.

Question 4: When a regional office converts to VBMS, are all new claims run through the paperless process or are only some new claims handled paperlessly?

Answer: Any new original or supplemental claim received on or after the date the regional office began using VBMS is sent to VA's scanning vendors and uploaded into VBMS.
Question 5: What data do you have that indicates that end-to-end paperless processing is faster and more accurate than the paper process? Have you conducted any head-to-head comparisons?

Answer: VBA's transformation plan is based on over 40 high-impact initiatives across people, process, and technology through a systematic and repeatable gap analysis process. The new organizational model (Segmented Lanes), Veterans Relationship Management, and VBMS are central to the transformation of VBA business processes.

Comparing productivity for all regional offices in the organizational model and VBMS for end of month February 2013 versus the same month in 2012 shows increased productivity per RVSR of 15.3 percent and 0.5 percent for VSRs and Claims Assistants overall. The data reflect the impact of overall transformation efforts, which are designed to improve production by 45-60 percent and quality by 14 points in CY 2015. It is difficult to extract each initiative from the combined people, process, and technology model to provide detail-level analyses toward the individual initiative contribution to productivity outcomes. At the end of April 2013, approximately 5,800 claims have been fully processed in VBMS in an average of 121.1 days fiscal year to date (FYTD).

VBA began deployment of VBMS Generation 1 in September of 2012, concluding the calendar year with 18 stations on the system. It is important to note that early adopters of first generation technology participated heavily in the development and refinement of efficiencies and functionality of the system, which had a direct impact on productivity as a result of the live test environment. These stations paved the way for the accelerated deployment of VBMS, which will enable VBA to track and measure productivity outcomes in a consistent and accurate manner once all regional offices are operating with the new technology and after a period of stabilization. The first 18 stations enabled VBA to also test business processes and functionality for the establishment of eFolders in VBMS and the model for tracking and shipping of paper-based claims with two scanning vendors.

Question 6: Provide the annual cost to date of the VBMS system, separately breaking out expenditures by IT and VBA.

Answer: VA will have invested $325.6 million (Information Technology (IT)) into VBMS development from FY 2010 through FY 2013. Additionally, VBA invested $103.3 million in general operating expenses (GOE) funding (non-IT) into VBMS during this same period to support development. Please see the chart below for an annual breakdown. FY12 consisted of heavy development activities resulting in functionality being released in FY13. As a direct result, the FY13 marginal sustainment dollars increase dramatically to maintain all functionality released during the relevant FY. As with most system development programs, the need for FTE oversight and leadership dissipates as the projects move from development to operations and maintenance, resulting in a decreased FTE requirement. Regarding the $22.28M for FY13, that is the current DME budget.

Fiscal Year	2010	2011	2012	FYTD 2013	TOTAL
VBMS (VBA - GOE	$29.20	$32.00	$31.60	$10.50	$103.30
VBMS (IT)	$63.00	$158.13	$82.17	$22.28	$325.58

Question 7: Identify the location of VetSuccess on Campus offices in FY 2013.

Answer: In FY 2011, VetSuccess on Campus (VSOC) became active on eight campuses:

University of South Florida, Tampa, Florida	Community College of Rhode Island, Rhode Island
San Diego State University , California	Rhode Island College, Rhode Island
Cleveland State University, Ohio	Arizona State University, Arizona
Salt Lake Community College, Utah	Texas A&M — Central Texas, Texas

In FY 2012, VSOC expanded to 24 additional campuses for a total of 32 campuses:

Eastern Michigan University, Michigan	Kellogg Community College, Michigan
Western Michigan University, Michigan	Washtenaw Community College, Michigan
University of Michigan-Ann Arbor, Michigan	Kalamazoo Valley Community College, Michigan
Norfolk State University, Virginia	Sam Houston State University, Texas
University of Texas-San Antonio College, Texas	University Of Maryland, Maryland
Tarrant County College District, South, Texas	Tarrant County College District, NE, Texas
Eastern Kentucky State University, Kentucky	University of Utah
Central New Mexico Community College, New Mexico	University of New Mexico
University of Alaska-Anchorage, Alaska	Boise State University, Idaho
Middle Tennessee State University, Tennessee	Portland State University, Oregon
Tidewater Community College at 4 campuses: Chesapeake, Norfolk, Portsmouth, and Virginia Beach, Virginia	

To date, the following 18 campuses have been identified for expansion in FY 2013:

Ohio State University, Ohio	Florida State University
George Washington University, DC	Central Texas College
Old Dominion University, Virginia	Troy University, Alabama
San Antonio College, Texas	California State University
ECPI University, Virginia	Hawaii Pacific University
George Mason University, Virginia	Mt. San Antonio College, Texas
University of Hawaii at Manoa	Texas A&M University
Tallahassee Community College, Florida	Long Beach City College, California
Citrus College, California	Leeward Community College, Hawaii

Question 8: Identify the annual participation by veterans and their family members since August, 2009 in the post-9-11 G.I. bill; the Montgomery G.I. bill; and other VA education assistance programs.

Answer: Please see the chart below.

Trainees by Education Program FY 2010 to FY 2012	FY **2010**	FY 2011	FY **2012**
Post 9/11 GI Bill (chapter 33)	**365,640**	**555,329**	**646,302**
Veterans/Servicemembers	313,982	440,918	498,427
Dependents	51,658	114,411	147,875
Montgomery GI Bill (chapter 30)	**247,105**	**185,220**	**118,549**
Veterans/Servicemembers	246,977	185,146	118,528
Dependents	128	74	21
Survivors and Dependents Educational Assistance (chapter 35)	**89,696**	**90,657**	**87,707**
Veterans/Servicemembers	0	0	0
Dependents	89,696	90,657	87,707
Montgomery GI Bill Selected Reserve (chapter 1606)	**67,373**	**65,216**	**60,393**
Veterans/Servicemembers	67,373	65,216	60,393
Dependents	0	0	0
Reserve Educational Assistance Program (chapter 1607)	**30,269**	**27,302**	**19,774**
Veterans/Servicemembers	30,269	27,302	19,774
Dependents	0	0	0
Post-Vietnam Era Veterans Educational Assistance Program (chapter 32)	**286**	**112**	**76**
Veterans/Servicemembers	286	112	76
Dependents	0	0	0
Veterans Retraining Assistance Program	**0**	**0**	**12,251**
Veterans/Servicemembers	0	0	12,251
Dependents	0	0	0
Total Education Programs	**800,369**	**923,836**	**945,052**
Veterans/Servicemembers	658,887	718,694	709,449
Dependents	141,482	205,142	235,603

Question 9: How has VA implemented the new statutory requirements to provide additional data about individual higher education institutions to veterans who are choosing where to use their post-9-11 GI bill benefits?

Answer: Public Law (P.L.) 112-249 required VA to conduct a market survey of commercially available off-the-shelf online tools that provide Veterans and Servicemembers with information regarding post-secondary education and available training opportunities. VA reviewed 11 different online tools, but none of the Web sites provided all the data outlined in Executive Order 13607 and P.L. 112-249. Based on the market survey results, VA will implement a GI Bill Comparison Tool to meet the

needs of the Market Survey. Building the tool is a two-step development process using both interim and long-term approaches.

The interim approach was completed on April 10, 2013, by embedding the Department of Education's (ED) College Navigator into the GI Bill Web site. College Navigator does not contain all the information nor does it have Veteran-specific information required by P.L. 112-249. VA is working with other agencies (i.e., ED, DoD, Consumer Financial Protection Bureau (CFPB)) to implement the long-term approach of leveraging CFPB's comparison tool to inform users of the value of their education benefits, cost of attendance, key measures of value such as graduation rates, and Veterans' outcome measures. Our expected completion date is April 2014.

Question 10: The budget includes $136 million for scanning of veterans' medical and service records to create the digital format necessary for the paperless claims processing system. Will that amount cover all the scanning required for the current claims caseload in FY 2014? What will be the outyear costs of scanning?

Answer: The $136 million scanning request will be sufficient to support VBA's FY 2014 estimated production claims workload.

Through FY 2018, VBA anticipates modest declines for annual scanning costs through the increasing use of online applications and electronic information feeds. However, VBA will also need to address paper archives at regional offices and address the needs of Veterans who submit their disability claims in paper.

Maintaining annual funding at FY 2014 levels through FY 2016 would allow VBA to aggressively eliminate its inventory of existing paper claims and address the paper records currently in regional offices. Once these are eliminated, assuming no significant increases in claims receipts, scanning costs in the out years will be less.

Question 11: Disability claims processing was slowed while the Department accepted new Agent Orange claims. Mr. Secretary, are there other presumptive conditions you are considering declaring that would generate future spikes in claims submissions?

Answer: At this time, VA is not planning to add any new conditions to the list of presumptive conditions; however, on August 10, 2012, VA proposed to amend its adjudication regulation concerning acute and sub-acute peripheral neuropathy, a condition that is already on the Agent Orange presumptive list. This proposed amendment is necessary to implement a VA decision to clarify and expand the terminology regarding presumption of service connection for peripheral neuropathy associated with exposure to certain herbicide agents. The number of new incoming claims is not expected to be significant, but VA is working with a contractor to mitigate the impact of nearly 70,000 cases that must be re-reviewed because of the *Nehmer* court stipulation. The proposed rule is available *at:* http://www.regulations.gov/MdocunnentDetail;D=VA-2012-VBA-0024-0001. The addition of new presumptive conditions, court rulings, and new laws that establish new entitlements can also impact the claim submission levels.

Veterans Health Administration

Question 12: How is the VA working to achieve 100% compliance with the CDC's new recommendation that all Baby Boomers be tested for hepatitis C?

Answer: VHA currently recommends testing those at risk including, but not limited to Veterans who served in the Vietnam era (dates of service 1964-1975). As of the end of calendar year 2011, VHA has tested approximately 65 percent of Veterans in VHA care who were born between 1945-1965 (Baby Boomers) for hepatitis C. In contrast, in the general U.S. population, birth cohort testing has been limited, and the U.S. Centers for Disease Control and Prevention (CDC) estimates that only 25 percent of chronically infected individuals have been tested and know their diagnosis.

VHA is planning the following steps regarding birth cohort testing:

1. Re-examination of current VHA policy in light of current recommendations by the CDC, the U.S. Preventive Services Task Force, and other advisory groups.
2. Based on this re-examination, the following measures by VHA's National Viral Hepatitis Program in the Office of Public Health (OPH), and VHA's National Center for Health Promotion and Disease Prevention are being considered:
    a. Revision of VHA's Preventive Services Guidance Statement on testing for hepatitis C virus (HCV).
    b. Additional training for VHA providers, especially in primary care, regarding hepatitis C testing and treatment.
    c. Creation of print and Web-based materials to educate patients and providers in VHA about HCV testing.
    d. Use of social marketing campaigns aimed at both providers and patients to increase awareness of hepatitis C.
    e. Analysis of facility-level testing data to identify best practices and areas for improvement.
    f. Use of telehealth and teleconsultation platforms to train providers, particularly those at Community-Based Outpatient Clinics, about hepatitis C testing.

Question 13: From 2001-2008, one-fifth of veterans with HCV had received antiviral therapy. How many veterans have received antiviral treatment for HCV in each of the last four years?

Answer: The most recent data available are as follows. Note that the population in care in any given calendar year is not exactly the same as in other years, e.g., those patients in care in 2012 may not have been in care in 2011 or other years, and vice- versa.

Calendar year	Number of HCV+ Veterans in VHA care	Number in treatment	Number ever treated
2012	173,416	6,405	38,860

2011	170,119	4,586	36,898
2010	165,005	5,376	35,841
2009	156,725	6,021	33,981

Question 14: Given the convergence of an aging population, rapid disease progression, and increasing incidence of cirrhosis in the veterans population, what steps is the VA taking to ensure that veterans served by the VHA have access to new therapies expected to enter the market in the coming 12-24 months that may be more tolerable and offer higher cure-rates than with a potentially shorter duration of treatment?

Answer: VHA has moved aggressively to make new treatments for hepatitis C available to affected Veterans in care:

- Within a week after FDA approval of the first direct acting antivirals (DAAs) active against HCV, VHA's Pharmacy Benefits Management Services (PBM) had drafted detailed instructions for use of these agents as part of a 3-drug regimen referred to as "triple therapy."
- Veterans were offered triple therapy with these new agents within a few weeks of approval, prior to addition to the VA National Formulary (VANF).
- Within 10 weeks of FDA approval, one agent had been added to the VANF, with the other readily and officially available as a nonformulary agent.
- At the same time that these agents were added to the VANF or made officially available, VA's Office of Public Health (OPH) sponsored a large (300-provider) training to educate VA providers on safe and effective use of these new drugs.
- PBM has conducted separate trainings, with participation of OPH staff, for clinical pharmacists on use of these new drugs.
- OPH produced educational materials to educate patients and providers on the new drugs.
- On August 26, 2011, VHA's Deputy Under Secretary of Health for Operations and Management issued a memorandum to Veterans Integrated Service Network (VISN) Directors establishing a policy that permits all new drugs to be considered as treatment options when they are clinically indicated, regardless of drug cost.
- To allow for appropriate resource planning, VISN and Facility Directors received detailed projections prepared by PBM and OPH showing the number of Veterans with HCV who were potential candidates for treatment with triple therapy. This allowed VISN-wide initiatives to allocate resources so as to maximize access to therapy.
- In collaboration with OPH, PBM trained hundreds of new providers to treat HCV.
- In collaboration with OPH, VHA's Office of Specialty Care Services has begun using a novel teleconsultation model to train providers at Community-Based Outpatient Clinics (CBOC) to deliver HCV care.

With regard to newer drugs that may be safer and more effective than current therapies, and which are expected to receive FDA approval over the next 12-24 months, VHA is planning the following steps:

- Detailed projections of the numbers of Veterans (both untreated and those who have failed previous treatment) who may benefit from these new drugs.
- Collaboration with PBM on the development of detailed instructions for use in anticipation of FDA approval, to facilitate rapid consideration of such drugs.
- After FDA approval, conduct new training initiatives to educate VA providers.
- Production of print and Web-based educational materials for patients and providers.
- Continued training of new HCV providers.
- Continued use of teleconsultation to expand access to patients seen at CBOCs.
- Collection of data on utilization and treatment outcomes.

Question 15: How many veterans are participating in the Million Veteran Study? What were the original participation projections by year? Have you had to revise those targets? What privacy and data releases have participants had to agree to if they participate in the study?

Answer: As of April 23, 2013, the Million Veteran Program (MVP) enrollment is as follows: 153,803 Veterans have completed enrollment (signed consent and HIPAA forms, and provided a blood sample); 213,180 Veterans have completed the Baseline Survey and are awaiting appointments for consent and blood draw.

Our initial projections were that it would take 5-7 years to enroll 1,000,000 Veterans, reaching a maximum enrollment of 225,000 per year by the end of the study. Overall, we have found that enrolling younger Veterans at VA medical centers is more difficult than expected and as well there are other administrative considerations. In addition, we have found that enrolling younger Veterans at VA medical centers is more difficult than expected. For this reason, we are currently exploring alternative methods such as Web- enrollment. Further, in order to make enrollment possible for all Veterans nationwide, including those in rural areas, we are exploring mechanisms that do not require a visit to a VA hospital to donate a blood specimen.

All MVP enrollees sign an informed consent form and a HIPAA authorization form. They agree to allow access to their medical records on an ongoing basis and add that information to the VA Central Research Database so that approved MVP researchers can follow their health and care for as long as they are alive. If the MVP enrollee participates or has participated in any other VA studies, they give permission to access data from these studies and add that data to the VA Central Research Database. MVP enrollees also agree to donate a blood sample that will be used for future studies related to characteristics of health, or any disease, illness, or condition. MVP enrollees also agree to future contact by MVP staff.

The samples and/or medical information will be available to approved researchers in a coded manner at VA, other Federal health agencies, and academic institutions within the United States for research projects approved by appropriate VA oversight committees.

Question 16: Identify the number of HUD-VASH slots supported by (1) HUD and (2) VA each year since the beginning of the program. Break out the new cohorts for each year and the cumulative totals.

Answer: VA, together with Federal and local partners, is making progress toward preventing and ending homelessness among Veterans. The Department of Housing and Urban Development—VA Supportive Housing (HUD-VASH) Program has been funded by Congress through annual appropriations for this program. Congress has provided funding to HUD to provide Section 8 Housing Choice vouchers and Congress has provided funding to VA for supportive wrap-around case management services to the Veterans housed in HUD-VASH units. HUD received $75 million, for each of the fiscal years 2008 through 2013, to fund the HUD-VASH Program with the exception of FY 2011, when $50 million was received. HUD-VASH funded approximately 10,000 vouchers in each of those years except for FY 2011, when approximately 7,350vouchers were funded. In total, these voucher allocations, as determined by HUD through consultation with VA, funded approximately 58,000 vouchers. FY 2014 funding for HUD, requested in the amount of $75 million, will support an additional 10,000 vouchers, allocated across the nation where the Point in Time and other pertinent data indicates relative need. Vouchers are only provided to the participating Public Housing Authorities (PHA) through these funding allocations by HUD's appropriations.

Fiscal Year	Number of HUD-VASH Vouchers Funded	Cumulative Number of HUD-VASH Vouchers Funded
FY 2008	10,150	10,150
FY 2009	10,290	20,440
FY 2010	10,096	30,536
FY 2011	7,349	37,885
FY 2012	10,450	48,335
FY 2013	10,000*	58,335

* HUD is presently working on finalizing the FY 2013 voucher allocation, VA anticipates that approximately 10,000 vouchers will be allocated in FY 2013.

VA specific purpose funding was set aside to hire case managers to provide the supportive wrap-around case management services necessary to assist these homeless Veterans in searching for appropriate permanent housing, connecting to treatment and other supportive services, and achieving and maintaining stability in their recovery. VA's initial allocation of resources through FY 2013 is detailed below. Increased funding in each FY is used to sustain existing staff and hire new program staff.

Fiscal Year	Total VA Appropriation in Millions	Number of Funded VA Program Staff	Approximate Approximate Number of Cumulative VA Staff Funded
FY 2008	$5	300	300

FY 2009	$26	380	680
FY 2010	$71	480	1,160
FY 2011	$151	320	1,480
FY 2012	$201	440	1,920
FY 2013	$245	560*	2,480

* Total funded staff includes multidisciplinary staff, including Peer Supports.

The HUD-VASH Program has been enormously successful placing homeless Veterans in HUD-VASH permanent supportive housing. While many Veterans continue using their vouchers for some time, when Veterans with HUD-VASH vouchers leave the program, the vouchers are re-issued to assist other homeless Veterans. As of March 27, 2013, over 51,500 Veterans have been housed since the inception of the HUDVASH Program in FY 2008. As of March 27, 2013, close to 42,000 Veterans are currently housed through HUD-VASH. HUD is in the process of finalizing the FY 2013 allocation of an additional 10,000 vouchers. Once this process is complete, there will be approximately 10,000 additional vouchers available to house homeless Veterans.

Information Technology

Question 17. Identify how much VA and DoD have each spent annually on the development of the integrated electronic health record since the 2009 agreement between the two Departments to produce one integrated record.

Answer: The following table highlight funds spent by VA by fiscal year.

VA (01T & VHA)	FY 2008 - 2010	FY 2011	FY 2012	* FY 2013 Planned
CAT- Sustainment	$ -	*7,600,000*	*12,041,554*	$ *65,000,000*
OIT - Development, Modernization and Enhancement (DME)	$ -	$	$ *78,955,008*	*104,000,000*
Sub Total	$ -	$ *7,600,000*	$ *90,996,562*	$ *169,000,000*
OIT - Pay	$ -	$	$ *8,458,000*	*9,381,287*
TOTAL OIT	-	$ *7,600,000*	$ *99,454,562*	*178,381,287*
VHA - NonPay	-	$ -	*16,488,404*	*47,615,283*
VHA - Pay	$ -	$ -	$ *12,959,221*	*16,201,122*
TOTAL VHA	$ -	-	$ *29,447,625*	*63,816,405*
Grand Totals	$ -	$ *7,600,000*	$ *128,902,187*	*$242,197,692*

The following table highlight funds spent by DoD by fiscal year.

DoD [redacted]	FY2008/09	FY 2010	FY 2011	FY 2012	FY 2013 Planned
DoD Legacy	$ 46,330,000				
DoD EHRWA		$ 70,470,000	$ 56,670,000	$ 42,160,000	
DoD 1EHR				$ 169,700,000	$ 522,660,000
GRAND TOTAL	$ 46,330,000	$ 70,470,000	$ 56,670,000	$ 211,860,000	$ 522,660,000

Question18: Mr. Secretary, you and the Secretary of Defense announced in February that because of new, higher budget estimates and risk assessments, each Department is now going to develop its own health record that will be interoperable with the other. VA has chosen to continue developing its VistA system and the DoD is analyzing which system it will pick.

a) How can the development of two systems cost less than one system used by both Departments?

Answer: At this point, we do not have any firm evidence that utilizing two separate cores would cost more or less than utilizing one core. VA and DoD have stated that the revised program approach to use existing technologies and the adjustment of the business rule to "adopt, buy, create" will drive costs down.

b)Is there any technical reason why one system couldn't be adapted to meet the needs of both Departments? Some have argued that one joint record cannot serve the unique needs of each Department. Mr. Secretary, has either Department ever presented you with unique needs that you consider more important than the advantages of working from the same IT system? If so, can you identify those unique needs?

Answer: There is no technical reason why one system could not be adopted to address the needs of both Departments. If DoD chooses to utilize a commercial off-theshelf (COTS) product instead of VistA, there is an expectation that DoD will provide substantial evidence and analysis to support their decision and clarify the benefits for both Departments. At this point, neither Department has presented unique needs that we consider to be more important. We have and will continue to ensure that all decisions are the best for both Departments, with regards to iEHR.

c)If two interoperable systems can achieve adequate functionality, why did the two Departments spend several years and hundreds of millions of dollars working on one integrated system? Is it fair to assume that each Department will be losing something if they aren't using the same electronic health record?

Answer: A single, joint, common iEHR that is open in architecture and nonproprietary in design is still the goal for both Departments. All funds obligated to date were obligated according to plan, and used to establish a foundation for both DoD and VA, irrespective of a decision on core systems. The focus of these efforts has remained on architecture, design, infrastructure, and initial clinical capabilities. The FY2014 VA budget request will be used to deliver on the goals to meet IOC and related scheduled

deliveries and to deploy an iEHR core based on VistA. In addition, iEHR is a key component of the larger Virtual Lifetime Electronic Record (VLER) initiative, which the President announced to allow VA, DoD, and others to easily share information on Servicemembers and Veterans. Through VLER and iEHR, VA will provide proactive care and benefits to Veterans that they have earned and deserve. The iEHR core based on VistA will meet VA's needs for serving Veterans and position us to meet the President's VLER goals.

Question 19: Identify the total costs in the FY14 request, broken down into sustainment and development, for iEHR/VLER health; VRM; and VBMS.
Response: The following chart provides VA's sustainment and development costs for iEHR/VLER Health; VRM; and VBMS:

	Dollar in Millions		
	FY2014 Sustainment	FY2014 Development	FY2014 Total
IEHR/VLER Health	91.732	251.882	343.614
VRM	35.194	120.157	155.351
VBMS*	80.355	20.777	101.132

Note: * VBMS does not include VETSNET (Sustainment: $6.263 and DME: $12057 for a total of $18.320)

Question 20: Provide a breakout of the components of the FY14 budget request by the nine resource bands identified on p. 5A-7 of volume II of the budget justification.

Answer: The attached chart provides a breakout of the VA budget request into the nine resource bands and provides a total for each.

Chart for question 20 - Components of the FY14 budget request mapped into the nine resource bands (p.5A-7, Vol II Budget Request)

Information Technology - Program Level Detail	FY2014 Budget Request	Staffing and Administration	Mandatory Sustainment	Activation Discretionary Sustainment	Other Discretionary Sustainment	iEHR and VLER Health Development	iEHR and VLER Health Marginal Sustainment	Major Transformational Initiatives - Development	Major Transformational Initiatives-Marginal Sustainment	Other Continuing Development
	$3,683,344	**$1,026,400**	**$1,748,085**	**$180,397**	**$156,762**	**$251,882**	**$38,700**	**$208,409**	**$36,709**	**$36,000**
MEDICAL	**$ 951,480**									
Medical 21st Century Core	**$ 35,469**	**$10,466**								
Access to Care (Medical Core) (DME)	$ -									
Access to Care (Medical Core) (OM)	$ 2,630		$2,630							
Health Informatics (Medical Core) (DME)	$ 7,774							$7,774		
Health Informatics (Medical Core) (OM)	$ 1,656		$1,656							
Health Provider Systems (Medical Core) (DME)	$ 4,200									$4,200
Health Provider Systems (Medical Core) (OM)	$ 15,441		$15,441							
Heatlhcare Efficiency (Medical Core) (DME)	$ -									
Heatlhcare Efficiency (Medical Core) (OM)	$ 2,820		$2,820							
Homelessness (Medical Core) (DME)	$ -									
Homelessness (Medical Core) (OM)	$ -									
Scheduling (DME)	$ -									
Scheduling (OM)	$ -									
NMOC (Medical Core) (DME)	$ -									
NMOC (Medical Core) (OM)	$ 937		$937							
VHA Research (Medical Core) (DME)	$ -									
VHA Research (Medical Core) (OM)	$ 10		$10							
Medical 21st Century Schedule Replacement	**$ -**	**$0**								
Scheduling Replacement (DME)	$ -									
Scheduling Replacement (OM)	$ -									
Medical 21st Century Laboratory	**$ -**	**$2,093**								
iEHR - Laboratory (DME)	$ -									
iEHR - Laboratory (OM)	$ -									
Laboratory (DME)	$ -									
Laboratory (OM)	$ -									

Chart for question 20 - Components of the FY14 budget request mapped into the nine resource bands (p.5A-7, Vol II Budget Request)

	FY2014 Budget Request	Staffing and Administration	Mandatory Sustainment	Activation Discretionary Sustainment	Other Discretionary Sustainment	iEHR and VLER Health Development	iEHR and VLER Health Marginal Sustainment	Major Transformational Initiatives - Development	Major Transformational Initiatives-Marginal Sustainment	Other Continuing Development
Medical 21st Century Pharmacy	**$ -**	**$1,954**								
iEHR - Pharmacy (DME)	$ -									
iEHR - Pharmacy (OM)	$ -									
Pharmacy (DME)	$ -									
Pharmacy (OM)	$ -									
Medical 21st Century RISE	**$ -**	**$0**								
RISE (DME)	$ -									
RISE (OM)	$ -									
Medical 21st Century CAPRI	**$ 1,720**	**$419**								
CAPRI (DME)	$ 1,100									$1,100
CAPRI (OM)	$ 620		$620							
Medical 21st Century My HealtheVet	**$ 24,758**	**$1,954**								
Mental Health (Medical My HeV) (DME)	$ -									
Mental Health (Medical My HeV) (OM)	$ -									
My HealtheVet (DME)	$ -									
My HealtheVet (OM)	$ -									
NMOC (Medical My HeV) (DME)	$ 18,022							$18,022		
NMOC (Medical My HeV) (OM)	$ 6,736		$2,725						$4,011	
Medical 21st Century Registries	**$ 4,088**	**$1,814**								
Access to Care (Registries) (DME)	$ -									
Access to Care (Registries) (OM)	$ -									
Homelessness (Registries) (DME)	$ -									
Homelessness (Registries) (OM)	$ 1,232		$1,232							
NMOC (Registries) (DME)	$ -									
NMOC (Registries) (OM)	$ -									
Registries (DME)	$ -									
Registries (OM)	$ 2,856		$2,856							
Medical 21st Century TeleHealth	**$ 11,164**	**$1,116**								

Chart for question 20 - Components of the FY14 budget request mapped into the nine resource bands (p.5A-7, Vol II Budget Request)

	FY2014 Budget Request	Staffing and Administration	Mandatory Sustainment	Activation Discretionary Sustainment	Other Discretionary Sustainment	iEHR and VLER Health Development	iEHR and VLER Health Marginal Sustainment	Major Transformational Initiatives - Development	Major Transformational Initiatives-Marginal Sustainment	Other Continuing Development
Access to Care (Medical TeleHealth) (DME)	$ -									
Access to Care (Medical TeleHealth) (OM)	$ -									
NMOC (Medical TeleHealth) (DME)	$ 9,843							$9,843		
NMOC (Medical TeleHealth) (OM)	$ 1,321		$592						$729	
Telemedicine (DME)	$ -									
Telemedicine (OM)	$ -									
Medical 21st Century Bar Code Expansion	**$ 1,700**	**$558**								
Bar Code Expansion (DME)	$ 1,700									$1,700
Bar Code Expansion (OM)	$ -									
Medical Legacy	**$ 62,261**	**$42,005**								
Access to Care (Medical Legacy) (DME)	$ 3,645							$3,645		
Access to Care (Medical Legacy) (OM)	$ 4,735		$1,971						$2,764	
Innovations	$ -									
Caregiver's (DME)	$ -									
Caregiver's (OM)	$ -									
Health Administration (DME)	$ -									
Health Administration (OM)	$ -									
Health Administrative Systems (DME)	$ 28,000									$28,000
Health Administrative Systems (OM)	$ 5,300		$4,300							$1,000
Health Provider Systems (Medical Legacy) (DME)	$ -									
Health Provider Systems (Medical Legacy) (OM)	$ 10,406		$10,407							
Homelessness (Medical Legacy) (DME)	$ -									
Homelessness (Medical Legacy) (OM)	$ 500		$500							
iEHR - Health Provider Systems (DME)	$ -									
iEHR - Health Provider Systems (OM)	$ -									
Mental Health (Medical Legacy) (DME)	$ -									
Mental Health (Medical Legacy) (OM)	$ 1,095								$1,095	
NMOC (Medical Legacy) (DME)	$ 4,782							$4,782		

Chart for question 20 - Components of the FY14 budget request mapped into the nine resource bands (p.5A-7, Vol II Budget Request)

	FY2014 Budget Request	Staffing and Administration	Mandatory Sustainment	Activation Discretionary Sustainment	Other Discretionary Sustainment	iEHR and VLER Health Development	iEHR and VLER Health Marginal Sustainment	Major Transformational Initiatives - Development	Major Transformational Initiatives-Marginal Sustainment	Other Continuing Development
NMOC (Medical Legacy) (OM)	$ 462								$462	
STDP/EWCA (Medical Legacy) (DME)	$ -									
STDP/EWCA (Medical Legacy) (OM)	$ -									
VHA Legacy Systems (DME)	$ -									
VHA Legacy Systems (OM)	$ 3,017		$3,017							
VHA Research (Medical Legacy) (DME)	$ -									
VHA Research (Medical Legacy) (OM)	$ 319		$319							
VLER (Medical Legacy) (DME)	$ -									
VLER (Medical Legacy) (OM)	$ -									
Medical IT Support	**$ 810,320**	**$632,865**								
Health Administrative Systems (DME)	$ -									
Health Administrative Systems (OM)	$ -									
iEHR (Medical IT Support) (DME)	$ -									
iEHR (Medical IT Support) (OM)	$ -									
VHA Facility Activation (DME)	$ -									
VHA Facility Activation (OM)	$ 90,082			$90,082						
VHA Facility Operations Allowance (DME)	$ -									
VHA Facility Operations Allowance (OM)	$ 10,385		$10,385							
VHA Hardware Maintenance (DME)	$ -									
VHA Hardware Maintenance (OM)	$ 47,114		$47,114							
VHA IT Infrastructure & Platform Upgrades (DME)	$ -									
VHA IT Infrastructure & Platform Upgrades (OM)	$ -									
VHA IT Lifecycle Management (DME)	$ -									
VHA IT Lifecycle Management (OM)	$ 66,579			$42,716	$23,862					
VHA IT Support Contracts (DME)	$ -									
VHA IT Support Contracts (OM)	$ 64,514		$64,515							
VHA Legacy Systems (DME)	$ -									
VHA Legacy Systems (OM)	$ 318,435		$318,435							

Chart for question 20 - Components of the FY14 budget request mapped into the nine resource bands (p.5A-7, Vol II Budget Request)

	FY2014 Budget Request	Staffing and Administration	Mandatory Sustainment	Activation Discretionary Sustainment	Other Discretionary Sustainment	iEHR and VLER Health Development	iEHR and VLER Health Marginal Sustainment	Major Transformational Initiatives - Development	Major Transformational Initiatives-Marginal Sustainment	Other Continuing Development
VHA Research IT Support (DME)	$ -									
VHA Research IT Support (OM)	$ 14,927		$14,927							
VHA Software License Maintenance (DME)	$ -									
VHA Software License Maintenance (OM)	$ 28,436		$28,436							
VHA Telecommunications (DME)	$ -									
VHA Telecommunications (OM)	$ 169,848		$169,848							
BENEFITS	**$ 329,607**									
Benefits 21st Century Paperless Delivery of Veterans Benefits	**$ 101,132**	**$7,675**								
VBMS (DME)	$ 20,777							$20,777		
VBMS (OM)	$ 80,355		$76,708						$3,648	
Benefits 21st Century Education	**$ 27,464**	**$419**								
Chapter 33 (DME)	$ -									
Chapter 33 (OM)	$ 27,464		$27,464							
Benefits Legacy	**$ 4,880**	**$15,351**								
Agent Orange (DME)	$ -									
Agent Orange (OM)	$ -									
C&P Application Maintenance (DME)	$ -									
C&P Application Maintenance (OM)	$ -									
Compensation (DME)	$ -									
Compensation (OM)	$ 253		$253							
Education (DME)	$ -									
Education (OM)	$ 1,627		$1,627							
Insurance (DME)	$ -									
Insurance (OM)	$ -									
Loan Guarantee (DME)	$ -									
Loan Guarantee (OM)	$ -									
VBA Transformational Initiatives (DME)	$ -									
VBA Transformational Initiatives (OM)	$ -									

Chart for question 20 - Components of the FY14 budget request mapped into the nine resource bands (p.5A-7, Vol II Budget Request)

	FY2014 Budget Request	Staffing and Administration	Mandatory Sustainment	Activation Discretionary Sustainment	Other Discretionary Sustainment	iEHR and VLER Health Development	iEHR and VLER Health Marginal Sustainment	Major Transformational Initiatives - Development	Major Transformational Initiatives-Marginal Sustainment	Other Continuing Development
Vocational Rehabilitation & Employment (DME)	$ -									
Vocational Rehabilitation & Employment (OM)	$ 3,000				$3,000					
Benefits Legacy VETSNET	**$ 18,320**	**$9,071**								
VETSNET (DME)	$ 12,057							$12,057		
VETSNET (OM)	$ 6,263		$6,263							
Benefits Legacy Memorials Legacy Development Support	**$ 13,552**	**$1,814**								
Memorials Legacy Development Support (DME)	$ 11,352							$11,352		
Memorials Legacy Development Support (OM)	$ 2,200								$2,200	
Benefits IT Support	**$ 164,259**	**$55,821**								
VBA & NCA Facility Activations (DME)	$ -									
VBA & NCA Facility Activations (OM)	$ 23,930			$23,930						
VBA & NCA Facility Operations Allowance (DME)	$ -									
VBA & NCA Facility Operations Allowance (OM)	$ 1,259		$1,259							
VBA & NCA Hardware Maintenance (DME)	$ -									
VBA & NCA Hardware Maintenance (OM)	$ 13,674		$13,674							
VBA & NCA IT Infrastructure & Platform Upgrades (DME)	$ -									
VBA & NCA IT Infrastructure & Platform Upgrades (OM)	$ -									
VBA & NCA IT Lifecycle Management (DME)	$ -									
VBA & NCA IT Lifecycle Management (OM)	$ -									
VBA & NCA IT Support Contracts (DME)	$ -									
VBA & NCA IT Support Contracts (OM)	$ 28,902		$28,902							
VBA & NCA Legacy Systems (DME)	$ -									
VBA & NCA Legacy Systems (OM)	$ 81,105		$81,105							
VBA & NCA Software License Maintenance (DME)	$ -									
VBA & NCA Software License Maintenance (OM)	$ 4,394		$4,394							
VBA & NCA Telecommunications (DME)	$ -									
VBA & NCA Telecommunications (OM)	$ 10,995		$10,995							
CORPORATE	**$ 819,100**									

Chart for question 20 - Components of the FY14 budget request mapped into the nine resource bands (p.5A-7, Vol II Budget Request)

	FY2014 Budget Request	Staffing and Administration	Mandatory Sustainment	Activation Discretionary Sustainment	Other Discretionary Sustainment	iEHR and VLER Health Development	iEHR and VLER Health Marginal Sustainment	Major Transformational Initiatives - Development	Major Transformational Initiatives-Marginal Sustainment	Other Continuing Development
Corporate 21st Century Core	**$ 19,433**	**$5,303**								
Corporate 21st Century Core (DME)	$ -									
Corporate 21st Century Core (OM)	$ -									
Human Capital (Corporate Core) (DME)	$ -									
Human Capital (Corporate Core) (OM)	$ 8,130		$8,131							
Human Resources & Administration (DME)	$ -									
Human Resources & Administration (OM)	$ -									
Innovations (DME)	$ -									
Innovations (OM)	$ -									
IOM (Corporate Core) (DME)	$ -									
IOM (Corporate Core) (OM)	$ 1,950		$1,950							
SCIP (Corporate Core) (DME)	$ -									
SCIP (Corporate Core) (OM)	$ 800		$800							
STDP/EWCA (Corporate Core) (DME)	$ -									
STDP/EWCA (Corporate Core) (OM)	$ 2,626		$2,626							
VA Learning Management System (DME)	$ -									
VA Learning Management System (OM)	$ -									
VA Talent Management System (DME)	$ -									
VA Talent Management System (OM)	$ 5,925		$5,925							
Enterprise Risk Management (ERM) (DME)	$ -									
Enterprise Risk Management (ERM) (OM)	$ -									
Financial Management System (FMS) Modernization (DME)	$ -									
Financial Management System (FMS) Modernization (OM)	$ -									
SCIP Enhancements (DME)	$ -									
SCIP Enhancements (OM)	$ -									
Section 508 Compliance Program (DME)	$ -									
Section 508 Compliance Program (OM)	$ -									
Corporate 21st Century E-Gov	**$ 13,800**	**$0**								

Chart for question 20 - Components of the FY14 budget request mapped into the nine resource bands (p.5A-7, Vol II Budget Request)

	FY2014 Budget Request	Staffing and Administration	Mandatory Sustainment	Activation Discretionary Sustainment	Other Discretionary Sustainment	iEHR and VLER Health Development	iEHR and VLER Health Marginal Sustainment	Major Transformational Initiatives - Development	Major Transformational Initiatives-Marginal Sustainment	Other Continuing Development
E-Gov (DME)	$ -									
E-Gov (OM)	$ 13,800		$13,800							
Corporate 21st Century SAM	**$ -**	**$0**								
SAM (DME)	$ -									
SAM (OM)	$ -									
Corporate IT Support ASD	**$ -**	**$10,885**								
ASD (DME)	$ -									
ASD (OM)	$ -									
Enterprise Architecture (DME)	$ -									
Enterprise Architecture (OM)	$ -									
ProPath (DME)	$ -									
ProPath (OM)	$ -									
Corporate IT Support Enterprise Cyber Security & Privacy	**$ 123,258**	**$78,009**								
Cyber Security (DME)	$ -									
Cyber Security (OM)	$ 118,422		$118,422							
iEHR (Corporate IT Support Enterprise Cyber Security & Privacy) (DME)	$ -									
iEHR (Corporate IT Support Enterprise Cyber Security & Privacy) (OM)	$ -									
NSOC (DME)	$ -									
NSOC (OM)	$ -									
Privacy (DME)	$ -									
Privacy (OM)	$ 4,836		$4,836							
Secure VA (DME)	$ -									
Secure VA (OM)	$ -									
Trusted Internet Connects Refresh (DME)	$ -									
Trusted Internet Connects Refresh (OM)	$ -									
VA Enterprise Intrusion Detection Systems (DME)	$ -									

Chart for question 20 - Components of the FY14 budget request mapped into the nine resource bands (p.5A-7, Vol II Budget Request)

	FY2014 Budget Request	Staffing and Administration	Mandatory Sustainment	Activation Discretionary Sustainment	Other Discretionary Sustainment	iEHR and VLER Health Development	iEHR and VLER Health Marginal Sustainment	Major Transformational Initiatives - Development	Major Transformational Initiatives-Marginal Sustainment	Other Continuing Development
VA Enterprise Intrusion Detection Systems (OM)	$ -									
Office of Assistant Secretary for Information Technology		**$9,769**								
Corporate IT Support ITOC_Q&P_SQAS		**$16,467**								
Corporate IT Support ITRM	**$ -**	**$17,304**								
ITRM (DME)	$ -									
ITRM (OM)	$ -									
Corporate IT Support PBX Replacement	**$ -**	**$0**								
PBX Replacement (DME)	$ -									
PBX Replacement (OM)	$ -									
Corporate Legacy	**$ -**	**$0**								
Capital Asset Management System (DME)	$ -									
Capital Asset Management System (OM)	$ -									
Financial Management System (FMS) (DME)	$ -									
Financial Management System (FMS) (OM)	$ -									
Payroll/HR System (DME)	$ -									
Payroll/HR System (OM)	$ -									
Enterprise IT Support	**$ 546,613**	**$70,194**								
Enterprise Facility Activations (DME)	$ -									
Enterprise Facility Activations (OM)	$ 6,985		$157	$6,828						
Enterprise Hardware Maintenance (DME)	$ -									
Enterprise Hardware Maintenance (OM)	$ 14,982		$14,983							
Enterprise IT Infrastructure & Platform Upgrades (DME)	$ -									
Enterprise IT Infrastructure & Platform Upgrades (OM)	$ -									
Enterprise IT Lifecycle Management (DME)	$ -									
Enterprise IT Lifecycle Management (OM)	$ 30,745			$16,841	$13,904					
Enterprise IT Support Contracts (DME)	$ -									
Enterprise IT Support Contracts (OM)	$ 82,873		$82,873							
Enterprise Legacy Systems (DME)	$ -									

Chart for question 20 - Components of the FY14 budget request mapped into the nine resource bands (p.5A-7, Vol II Budget Request)

	FY2014 Budget Request	Staffing and Administration	Mandatory Sustainment	Activation Discretionary Sustainment	Other Discretionary Sustainment	iEHR and VLER Health Development	iEHR and VLER Health Marginal Sustainment	Major Transformational Initiatives - Development	Major Transformational Initiatives-Marginal Sustainment	Other Continuing Development
Enterprise Legacy Systems (OM)	$ 57,038		$57,038							
Enterprise License Expenses (DME)	$ -									
Enterprise License Expenses (OM)	$ 142,216		$142,216							
Enterprise Software License Maintenance (DME)	$ -									
Enterprise Software License Maintenance (OM)	$ 60,905		$60,905							
Enterprise Telecommunications (DME)	$ -									
Enterprise Telecommunications (OM)	$ 92,389		$92,389							
National Data Processing Center (DME)	$ -									
National Data Processing Center (OM)	$ 19,699		$19,699							
TAC Fees (DME)	$ -									
TAC Fees (OM)	$ -									
VACO Facility Operations Allowance (DME)	$ -									
VACO Facility Operations Allowance (OM)	$ 953		$953							
Enterprise Management Framework (DME)	$ -									
Enterprise Management Framework (OM)	$ -									
Product Development Tools (DME)	$ -									
Product Development Tools (OM)	$ 37,265		$37,265							
SAM (DME)	$ -									
SAM (OM)	$ 561		$561							
Enterprise Telephony Strategy	**$ 115,996**	**$0**								
Telephony (DME)	$ -									
Telephony (OM)	$ 115,996				$115,996					
INTERAGENCY	**$ 556,758**									
Federal Health Information Exchange	**$ 7,818**	**$0**								
Federal Health Information Exchange (DME)	$ -									
Federal Health Information Exchange (OM)	$ 7,818		$7,818							
Interagency 21st Century - Veterans Interoperability	**$ 43,386**	**$7,396**								
Common Services (DME)	$ -									

Chart for question 20 - Components of the FY14 budget request mapped into the nine resource bands (p.5A-7, Vol II Budget Request)

	FY2014 Budget Request	Staffing and Administration	Mandatory Sustainment	Activation Discretionary Sustainment	Other Discretionary Sustainment	iEHR and VLER Health Development	iEHR and VLER Health Marginal Sustainment	Major Transformational Initiatives - Development	Major Transformational Initiatives-Marginal Sustainment	Other Continuing Development
Common Services (OM)	$ 2,120		$2,120							
Federal Information Sharing Technologies (FIST) (DME)	$ -									
Federal Information Sharing Technologies (FIST) (OM)	$ -									
ITRM (DME)	$ -									
ITRM (OM)	$ -									
Repositories (DME)	$ -									
Repositories (OM)	$ 35,063		$35,063							
Standards and Terminology Services (STS) (DME)	$ -									
Standards and Terminology Services (STS) (OM)	$ 4,326		$4,326							
VLER Services (DME)	$ -									
VLER Services (OM)	$ 1,876		$1,876							
InterAgency 21st Century Core	**$ 343,614**	**$13,816**								
Common Services (DME)	$ -									
Common Services (OM)	$ -									
iEHR (Interagency 21st Century Core) (DME)	$ -									
iEHR (Interagency 21st Century Core) (OM)	$ -									
iEHR - Health Provider Systems (DME)	$ -									
iEHR - Health Provider Systems (OM)	$ -									
iEHR - Laboratory (DME)	$ 5,000					$5,000				
iEHR - Laboratory (OM)	$ 5,584		$3,989				$1,595			
iEHR - Pharmacy (DME)	$ 4,000					$4,000				
iEHR - Pharmacy (OM)	$ 8,775		$3,989				$4,786			
iEHR - Scheduling (DME)	$ 30,000					$30,000				
iEHR - Scheduling (OM)	$ -									
iEHR (Corporate IT Support Enterprise Cyber Security & Privacy) (DME)	$ -									
iEHR (Corporate IT Support Enterprise Cyber Security & Privacy) (OM)	$ -									

Chart for question 20 - Components of the FY14 budget request mapped into the nine resource bands (p.5A-7, Vol II Budget Request)

	FY2014 Budget Request	Staffing and Administration	Mandatory Sustainment	Activation Discretionary Sustainment	Other Discretionary Sustainment	iEHR and VLER Health Development	iEHR and VLER Health Marginal Sustainment	Major Transformational Initiatives - Development	Major Transformational Initiatives-Marginal Sustainment	Other Continuing Development
iEHR (DME)	$ 197,082					$197,082				
iEHR (OM)	$ 70,672		$43,139				$27,533			
VLER Health (DME)	$ 15,800					$15,800				
VLER Health (OM)	$ 6,701		$1,915				$4,786			
InterAgency 21st Century Enrollment System Redesign	**$ -**	**$977**								
Enrollment (DME)	$ -									
Enrollment (OM)	$ -									
Enrollment System Modernization (DME)	$ -									
Enrollment System Modernization (OM)	$ -									
InterAgency 21st Century One Vet	**$ 155,350**	**$9,489**								
Veterans Relationship Management (DME)	$ 120,157							$120,157		
Veterans Relationship Management (OM)	$ 35,194		$13,394						$21,800	
E-Authentication (DME)	$ -									
E-Authentication (OM)	$ -									
VBA Transformational Initiatives (DME)	$ -									
VBA Transformational Initiatives (OM)	$ -									
Warrior Support (DME)	$ -									
Warrior Support (OM)	$ -									
InterAgency 21st Century PIV	**$ 6,590**	**$1,396**								
Safety & Security Initiative (PIV for HSPD-12) (DME)	$ -									
Safety & Security Initiative (PIV for HSPD-12) (OM)	$ 6,590		$6,590							
Total IT Activities	**$ 2,656,944**									

Question 21: Provide the table of IT sustainment projects with both an FY13 and FY14 request and change column.

Answer: Please find the requested table below:

Sustainment Detail
(Dollars in Thousands)

	FY2013[1]	FY2014	Delta
Mandatory Sustainment	$1,517,210	$1,748,08	$230,875
Software License and Maintenance	$392,475	$307,845	($84,630)
Corporate Data Center Operation's Charges	$237,994	$300,000	$62,006
IT Support Contracts	$276,117	$283,843	$7,726

Mandatory Sustainment	$1,517,210	$1,748,085	$230,875
Software License and Maintenance	$392,475	$307,845	(84,630)
Corporate Data Center Operation's Charges	$237,994	$300,000	$62,006
IT Support Contracts	$276,117	$283,843	$7,726
Telecommunication	$274,834	$269,000	($5,834)
Hardware Maintenance	$107,302	$103,627	($3,675)
Major Transformational Initiatives and iEHR and VLER Health	$59,000	$162,464	$103,464
Information Security	$127,000	$123,258	($3,742)
National Data Center Program (NDCP)		$19,699	$19,699
Other	$42,488	$178,349	$135,861
Discretionary Sustainment	**$120,000**	$337,159	**$217,159**
Activations	$91,700	$180,397	$88,697
Voice as a Service	$0	$115,996	$115,996
Hardware and Desktop Refresh	$28,300	$37,766	$9,466
Vocational Rehabilitation and Employment-Transition Assistance program	$0	$3,000	$3,000
Marginal Sustainment	**$174,836**	**$76,409**	($98,427)
Major Transformational Initiatives	$65,000	$36,709	($28,291)
iEHR and VLER Health	$109,836	$38,700	($71,136)
Other Marginal Sustainment		$1,000	$1,000
Total Sustainment	**$1,812,046**	$2,161,653	**$349,607**

[1]FY 2013 Enacted prior to rescission.

Question: 22: What is the reason for the $25 million increase in the IT staffing and administration subaccount for "other services"?

Answer: The "other services" account includes funding for enterprise architecture, design, and IT strategic planning. Comparing the $25M increase from the FY13 President's budget ($110M) to the FY14 President's budget ($135M) does not present an accurate picture, because the amount in FY13 is understated. In fact, the amount spent in FY12 was actually $122.9M. The FY14 budget estimate reflects an increase of $12.1M over FY12.

Construction

Question 23: Mr. Secretary, Members of the Louisiana delegation have expressed their great concern about the problems the VA is having in getting authority to lease buildings for badly needed outpatient clinics in their state. As I understand it, the authorizers have been stymied by a Congressional Budget Office ruling that the leases are capital, rather than operating, leases. The CBO position means that the entire lease cost is scored in the first year, creating offset requirements that the authorizers cannot meet. OMB has a different scorekeeping convention, so the leases appear again in the budget without offsets. This scorekeeping offset has broad implications for your facilities program. In the face of CEO's implacable ruling, what alternatives are you considering? Do you

plan to do outright construction rather than leasing, even though that may create undesirable long-term costs?

Answer: Clerk's Note: The VA did not provide an answer to this question.

National Cemetery Administration

Question 24: I am very pleased that Congress was able to pass a Military Construction-VA conference report this year rather than extending the continuing resolution for these agencies. In particular, the conference report gave both the House and the Senate the opportunity to express their common view about proper burial procedures at VA national cemeteries. The conference report requires you to issue guidelines that ensure that veterans' families may hold committal services with any secular or religious content they desire and with the participation of any people or organizations they choose. Mr. Secretary, I'd like to hear what progress your agency is making in issuing these guidelines. When do you expect them to take effect?

Answer: Public Law 113-6, the Consolidated and Further Continuing Appropriations Act, 2013, requires VA to issue guidelines on committal services held at cemeteries under the jurisdiction of the National Cemetery Administration. Additionally, Public Law 112-260, the Dignified Burial and Other Veterans' Benefits Improvement Act of 2012, amended title 38, United States Code, as well as directed VA to prescribe regulations.

VA is undertaking the formal rulemaking process, in accordance with the Administrative Procedure Act (APA), to implement new statutory provisions and issue administrative guidelines. As required by the APA, the regulations will be subject to the formal notice and comment rulemaking process to allow public input and comment. VA will ensure copies of both the proposed and final rule are submitted to Congress. The timeline for issuing the final rule will be dependent on the extent of comments received from the public.

The regulations will inform the public of VA's existing practices related to committal services held at VA national cemeteries; clarify VA's role to assist families in arranging committal services held at VA national cemeteries; provide information about available honor guard services; restate VA's ongoing practice of allowing access to public places for cemetery visitors and volunteer honor guards, to include committal shelters, chapels and benches for prayer, contemplation, and reflection; and to ensure respect of a decedent's wishes, and clarify that families are permitted to display religious and other symbols at committal services.

Crosscutting

Question 25: Please identify by account the amount of funding that is included in the FY 2014 budget request for Federal payraises.

Answer: Please see the attached spreadsheet on VA payraises.

VA Discretionary Appropriated Accounts with Civilian Full-Time Equivalent Employment

($ in thousands)	2014 Request without pay	2014 Payraise .5% 1st Quarter	2014 Payraise 1.0% 2nd-4th	2014 Total Request
Veterans Health Administration				
Medical Services	43,537,085	44,276	133,139	43,714,500
Medical Support and Compliance	5,995,523	9,313	28,164	6,033,000
Medical Facilities	4,856,801	3,774	11,425	4,872,000
Subtotal VHA without collections	54,389,409	57,363	172,728	54,619,500
Medical and Prosthetic Research	583,572	259	1,555	585,386
National Cemetery Administration	249,139	123	738	250,000
Departmental Administration:				
VBA-GOE	2,424,784	3,677	27,029	2,455,490
General Administration	400,283	388	2,352	403,023
Office of Inspector General	115,427	111	873	116,411
Information Technology	3,676,709	737	5,898	3,683,344
Veterans Housing Benefit Program Fund	156,917	128	1,385	158,430
Subotal Departmental Administration	**7,959,888**	**5,041**	**37,537**	**8,002,466**
Total Discretionary without MCCF	**63,182,008**	**62,786**	**212,558**	**63,457,352**

Prepared by: Paola Zuco

Question 26: Mr. Secretary, Members of Congress and the public were shocked last year by the revelations of inappropriate spending and lax internal management at several large VA training conferences held in Orlando, Florida. OMB has issued guidance to executive branch agencies in an attempt to control spending on conferences, meetings and travel. Congress also included conference limitations in the omnibus bill passed in March. Can you describe for us the safeguards, management controls, and spending limits you have put in place to meet these statutory requirements and to prevent a situation like the Orlando conferences from happening again?

Answer: The Department of Veterans Affairs (VA) employs over 320,000 employees who provide high quality health care, benefits, and services to Veterans every day. VA is the Nation's largest integrated health care system with nearly 1,300 centers of care serving 8.6 million Veterans across the country. A large number of VA doctors, nurses, claims processors and other employees directly benefit from training events every year. Continuous workforce training and development is essential to delivering timely and quality VA care and services our Veterans have earned and deserve. VA holds centralized training forums to enhance the delivery of health care, benefits, and memorial services unique to Veterans. This includes employee development through critical training to improve customer service and the timely delivery of benefits and services; clinical training, which includes post-deployment care, treatment of chronic conditions, mental health, suicide prevention; and strategies to eliminate Veteran homelessness. Our training events are designed to achieve our goals - better access, eliminate the backlog, and end Veteran homelessness by training and developing our employees and empowering them to provide the best care and services possible for our Nation's Servicemembers and Veterans.

VA has implemented a comprehensive action plan to revise and strengthen policies and controls on the planning and execution of training conferences and events. These actions are consistent with the recommendations in the September 30, 2012 Inspector General report and are reflected in VA policy issued on September 26, 2012.

Stringent internal controls for training conferences are in place and oversight is provided by the senior executives in the Department. Further, the newly established Training Support Office ensures consistency and adherence with all appropriate regulations and requirements as the Department balances critical training requirements to ensure we achieve stated goals and objectives while minimizing costs.

Automating data collection is essential to provide accurate and timely information for senior leaders so they can execute their responsibilities and respond to queries for training related events from Congressional and other Federal oversight bodies. VA is currently engaged in developing and delivering an automated data collection tool to increase accountability, control conference spending, and produce congressionally required reports.

VA's Conference Oversight Memorandum dated September 26, 2012, supersedes all previously issued conference guidance.

The approval authorities:

- A Senior Executive must approve any conference under $20,000.
- Two Senior Executives, the Conference Certifying Official (CCO) and the Responsible Conference Executive (RCE), are appointed when a conference exceeds $20,000 to ensure adherence to all applicable statutes, regulations, and policies when planning and executing the approved conference.
- An Under Secretary or Assistant Secretary must approve any conference within the threshold $20K to $100K.
- The Deputy Secretary is responsible for approving conferences exceeding $100K to $500K.
- Conferences exceeding $500K require a waiver by the Secretary.

A Quarterly Conference Planning and Execution Briefing is now required at least 120 days prior to the quarter of execution. This briefing outlines all the conferences planned for the targeted quarter to include cost, attendees, location, purpose and outcomes.

The VA conference process has four phases: Concept, Development, Execution, and Reporting.

- The Concept Phase is a disciplined conference authorization process. In October 2012, VA began our quarterly Concept Authorization Briefing as part of the quarterly Conference Planning and Execution Briefing Cycle where senior officials review all events to ensure the best value prior to being authorized to enter the Development Phase.
- The Development Phase builds the business case for the event; provides the guidance for the planning and execution of the potential conferences; appoints a Senior Executive as the CCO and a Senior Executive as the RCE. The CCO certifies the event details are in compliance with all directives. The event plan is then submitted through the appropriate channels to the approving official for approval, disapproval or modification of the planned event.
- The Execution Phase covers the period after the conference plan has been approved and the responsible organization begins to execute the approved plan. The RCE is responsible for executing the approved plan in accordance with laws, regulations, and policy. Additionally, the RCE oversees the spending and contract execution, approving any changes to contract agreements or increases in spending.
- The Reporting Phase covers the period after the execution of the conference. The RCE submits an After Action Review (AAR) reflecting how the event was conducted; providing conference attendance and details on how the spending was tracked and reported in accordance with P.L. 112-154 and OMB M-12-12. The Administrations and Staff Offices leadership review the AAR to verify that the event was executed in accordance with the plan and all applicable policies and regulations.

Question 27: Provide a chart showing the shifts of FTE and accompanying dollars back and forth from the IT and Medical Care accounts in the FY14 budget. Then provide a chart that shows FTE in those accounts on a comparable basis from FY13 to the FY14 request.

Answer: OIT and VHA realigned personnel in FY 2014 as shown in the following table.

VHA/OIT Realignment	FTE			Obligations ($M)		
	Medical Services	Medical Support & Compliance	OIT	Medical Services	Medical Support & Compliance	OIT
Austin Human Resources Support Services		53	(53)		$6.346	($6.346)
Clinical Applications Coordinator	53		(53)	$6.138		($6.138)
Information Technology Support Staff		(26)	26		($7.989)	$7.989
Total	53	**27**	(80)	$6.138	($1..643)	**($4.495)**

The three movements of personnel are as follows:

- With respect to the Austin Human Resources Support Services, the budget reflects a realignment of 53 FTE and $6.346 million from OIT to Medical Support and Compliance. OIT utilized HR specialists but determined that this function is aligned more efficiently within VHA operations. In 2012 and 2013, the staff was supported by OIT on a reimbursable basis, based upon a reassignment that was effective in December 2011.
- The second movement of personnel addressed Clinical Application Coordinators (CAC). The budget realigned 53 FTE and $6.138 million from OIT to VHA. CAC employees provide direct support to clinical services and coordinate facility efforts in support of VHA's Medical Center Management. As a result of the creation of the IT Systems Appropriation for VA in 2006, the CACs were assigned to OIT and paid by that appropriation, but are better assigned to VHA due to the function they perform.
- Finally, $7.989 million and 26 FTE were moved from VHA's Office of Informatics and Analytics to the Office of Information and Technology. This also moves the same number of dollars and people from the Medical Support and Compliance Appropriation to the IT Systems Appropriations. VA, through a detailed operational analysis, determined that these staff performed functions that were better aligned under OIT.

[Questions for the Record submitted by Congressman Fortenberry for the Honorable Eric K. Shinseki follows:]

Question 1. The operating rooms at the VA Hospital in Omaha, Nebraska - just outside of my district - were recently closed for repairs. I have fielded numerous concerns from my constituents about this and would like to ask: does the VA have the resources necessary to care for our veterans in a safe manner? The Omaha facility is priority number 18 on the list of VA major construction projects. In the past, prioritization has been determined in part by a facility's vulnerability to natural disasters. Now, the VA is looking at having to replace hospitals - like in Omaha - that are 50 plus years old and facing structural disasters. In light of this, does the VA's prioritization methodology need to be revised? And what is the VA doing to ensure major construction projects are completed in a timely manner?

Answer: The FY 2014 Budget Request and **FY** 2014 Advanced Appropriations provide the necessary resources to care for our Nations Veterans. With the 2014 Budget Request, VA requested resources to allocate funding between a mix of operating and capital accounts, to provide the best mix of services for Veterans. In addition to expanding access to VA services through the construction and renovation of facilities, VA provides access to Veterans through non-capital solutions such as: Fee care, telehealth, beneficiary travel, Veteran transportation services, etc.

In FY 2014, the Budget Request funds the completion of the Mental Health Building in Seattle, Washington, which is the highest priority partially funded project from the list of outstanding projects that previously received Congressionally appropriated funds. VA plans to award a contract for that project within the budget fiscal year, for the next phase of completion of the Mental Health Building.

VA supports alternative means to more effectively manage our real property portfolio. The President's proposed Civilian Property Realignment Act, along with expansion of VA's enhanced use lease program, would provide a unique opportunity to realign VA's infrastructure to be better aligned to Veteran's needs.

VA's goal is to award a construction contract in the same year that initial funding is received. VA closely aligns completion of construction documents with the funding year for receipt of construction dollars, to assure that projects are ready to be awarded in the year initial funding is provided. Due to the number of projects with partial funding for design, it may appear that projects are not being completed timely. This issue is more of a matter of prioritization of resources than slowness of project completion. VA monitors projects during construction, to assure that construction progress is staying on track. VA also works with the contractors when the construction is delayed or is behind schedule.

Question 2. In thinking creatively about how to deliver reasonable services to our veterans for **a** reasonable amount of funding, one issue that I do not believe has been fully considered by the VA is partnering or collocating with military hospitals and clinics. In pursuing this, I believe that the VA could deliver better services to veterans and

continue to preserve the mark of quality that the VA brings to the table. Given the changes that will be occurring to the VA's load of patients in the future, are there alternatives like partnering or collocating with other institutions (military and otherwise) that the VA could more aggressively consider to alleviate constraints on construction funding?

Answer: VHA currently has over 200 sharing agreements with about 60 DOD facilities for shared services including clinical, administrative, and education. For example, VA Nebraska — Western Iowa Health Care System has two sharing agreements with the 55th Medical Group, Offutt Air Force Base. Shared services include: Inpatient and Ambulatory Mental Health Services, Emergency Medical Care, and Ancillary Services (Pathology, Pharmacy, and Radiology). Ten Joint Venture sites share a special working relationship to provide care to beneficiaries of both departments. Additionally, all VA Medical Centers are TRICARE network providers and can provide healthcare services to all TRICARE eligible beneficiaries. Both VA and DoD consistently work to bring local facility leadership together, to explore additional opportunities for sharing. Regulations stipulate that caring for DoD beneficiaries cannot displace or delay care to a Veteran.

The VA/DoD Construction Planning Committee is a joint effort between the Departments to explore opportunities for facility partnerships. DoD participates in the VA Strategic Capital Investment Planning (SCIP) process, and VA participates in DoD's Capital Investment Decision Model (CIDM) to identify areas where joint or co-located facilities could provide for cost savings.

Importantly, in VA's FY 2014 budget submission, VA has requested Congressional legislative authorization to allow VA to plan, design, construct, or lease shared medical facilities with the goal of improving the access to, and quality and cost effectiveness of, the health care provided by the Department and other Federal agencies (for example, the Department of Defense) to their beneficiaries. The proposal would allow the Department to transfer and/or receive funds (major and minor construction) to/from another Federal agency for use in the planning, design, and/or construction of a shared medical facility. It would also allow the transfer (from the medical facility appropriation) or receipt of funds to/from other Federal agencies for the purpose of leasing space for a shared medical facility, after section 8104 authorization requirements have been met. In order to foster collaboration, VA will also request legislative action to amend the definition of a "medical facility" to include any facility or part thereof which is, or will be, under the jurisdiction of the Secretary, or as otherwise authorized by law, for the provision of health-care services. We appreciate Congress' consideration of this request.

The Government Accountability Office's report directed by Congress provided additional information on DoD and VA joint activities (http://www.craomovhoroducts/GA0-12-992). In addition, VA provided a report in February 2013 to Congress entitled VA Strategic Capital Plan for Joint Medical Facilities in response to language in Senate Report 11229 which discusses these issues in detail.

Current Joint Venture Sites

Albuquerque, NM

- New Mexico VA Health Care System, Albuquerque, NM
- 377th Medical Group Clinic, Kirtland Air Force Base (AFB)

Anchorage, AK

- Alaska VA Health Care System

- 3rd Medical Group, Elmendorf AFB

El Paso, TX

- El Paso VA Health Care System
- William Beaumont Army Medical Center, Ft. Bliss

Fairfield, CA

- Northern California VA Health Care System
- David Grant Air Force Medical Center, 60th Medical Group, Travis AFB

Honolulu, HI

- VA Pacific Islands Health Care System
- Tripler Army Medical Center

Key West, FL

- Miami VA Health Care System
- Naval Hospital Jacksonville

Las Vegas, NV — Mike O'Callaghan Federal Hospital

- VA Southern Nevada Health Care System
- 99th Medical Group, Nellis AFB

Biloxi, MS (Centers of Excellence Model)

- VA Gulf Coast Veterans Health Care System
- 81st Medical Group, Keesler Medical Center, Keesler AFB

Charleston, SC

- Ralph H. Johnson VA Medical Center
- Charleston AFB Clinic
- Naval Health Clinic Charleston (Goose Creek)
- Naval Hospital Beaufort

North Chicago, IL — CAPT James A. Lovell Federal Health Care Center (Dedication as single Federal facility Oct 1, 2010.)

- North Chicago VA Medical Center
- Naval Health Clinic Great Lakes

Question 3. I'd like to ask about the VA's use of medical isotopes derived from non- highly enriched uranium. The use of non-HEU isotopes in medical procedures would be consistent with the goal of minimizing the dangers associated with the use of weapons- grade nuclear material. Please tell me more about what the VA's efforts are in this regard and what impact those efforts might have on the domestic and international markets for non-HEU medical isotopes.

Answer: VA has been an active participant on the White House Interagency Policy Committee (WH IPC), a group comprised of representatives from key U.S. government departments and agencies involved in the regulation, use, import and international trade concerning radioactive isotopes, since April 2012. The WH-IPC has been tasked with managing the transition from high enriched uranium (HEU) to non-HEU radioisotope production and assisting in creation of domestic supplies of radioisotopes.

VA supports creation of a domestic supply of medical isotopes derived from non-highly enriched uranium (HEU) and understands that success of the transition to non-HEU and creation of domestic supplies of radioisotopes will rely upon the transition of the medical isotope industry to a full-cost-recovery, market-driven model with conversion of global medical isotope production from HEU to non-HEU targets.

Although costs of reactor conversion are estimated to be low (1 to 2 percent above current), the actual costs per dose at full cost recovery are uncertain due to a lack of industry transparency.

VA administered 366K doses (FY 2012) of radiopharmaceuticals labeled with Tc-99m representing approximately 2-3 percent of total U.S. Tc-99m utilization per year. The numerical impact (total doses and revenue to vendors) of preferential procurement by VA will be very small. There are currently no vendors who have established GSA
prices.

The majority of doses (more than 90 percent) of Tc-99m labeled radiopharmaceuticals in VHA are obtained as "unit dose" from local/regional vendor radiopharmacies. Estimates of incremental costs of non-HEU Tc-99m labeled radiopharmaceutical doses are approximately 25 percent resulting in a minimum estimated increased average dose cost from $56 per unit dose to $70 per unit dose. Preferential procurement of non-HEU derived Tc-99m would initially impact the small number (less than 10 percent) of VHA facilities that purchase Tc-99m generators for on-site labeling of radiopharmaceutical kits as non-HEU Mo/Tc-99m generators are commercially available.

Despite the availability of incremental reimbursement for radiopharmaceutical doses using non-HEU derived Tc-99m for Medicare-eligible outpatients, availability and potential VHA preferential procurement of non-HEU derived Tc-99m labeled unit dose radiopharmaceuticals will depend upon centralized nuclear pharmacies' transition to unit doses labeled with non-HEU derived Tc-99m with (anticipated) Federal Schedule pricing.

VA Discretionary Appropriated Accounts with Civilian Full-Time Equivalent Employment

($ in thousands)	2014 Request without pay	2014 Payraise .5% 1st Quarter	2014 Payraise 1.0% 2nd-4th	2014 Total Request
Veterans Health Administration				
Medical Services	43,537,085	44,276	133,139	43,714,500
Medical Support and Compliance	5,995,523	9,313	28,164	6,033,000
Medical Facilities	4,856,801	3,774	11,425	4,872,000
Subtotal VHA without collections	54,389,409	57,363	172,728	54,619,500
Medical and Prosthetic Research	583,572	259	1,555	585,386
National Cemetery Administration	249,139	123	738	250,000
Departmental Administration:				
VBA-GOE	2,424,784	3,677	27,029	2,455,490
General Administration	400,283	388	2,352	403,023
Office of Inspector General	115,427	111	873	116,411
Information Technology	3,676,709	737	5,898	3,683,344
Veterans Housing Benefit Program Fund	156,917	128	1,385	158,430
Subotal Departmental Administration	7,959,888	5,041	37,537	8,002,466
Total Discretionary without MCCF	63,182,008	62,786	212,558	63,457,352

Prepared by: Paola Zuco

[Questions for the Record submitted by Congressman Bishop for the Honorable Eric K. Shinseki follows:]

Question 1: How many claims has the VBA processed so far in FY 2013?

Answer: As of April 23, 2013, VBA has completed 559,230 claims fiscal year to date (FYTD), which is 10,347 more claims than completed last year during this time period.

Question 2: According to the FY 2014 budget documents, the incoming claims volume will increase from 1.2 million in 2013 to 1.3 claims in 2014. In your testimony you state that "As more than one million troops leave service over the next 5 years, we expect our claims workload to continue to rise." The FY 2014 budget includes funding for only 94 additional disability claims processors over the FY 2013 amount. Wouldn't it help to request more claims processors so you can have them in place and ready to deal with the influx of claims that will come in over the next five years?

Answer: VA is focused on providing a long-term solution to a decades-old problem. VBA is retraining, reorganizing, streamlining business processes, and building and implementing technology solutions based on the newly redesigned processes to improve benefits delivery. Several transformation initiatives, as described below, are focused on increasing the number of ratings completed per full-time employee (FTE). VBA is also completing a thorough evaluation of its ability to meet the processing demands of incoming workload, through "demand" and "capacity" analyses, which are currently in progress.

VBA's new organizational model, which incorporates a case-management approach to claims processing, has been implemented at all 56 regional offices. VBA projects that the segmented lanes initiative, part of this new organizational model, will accelerate simpler claims, predictably taking less time through the "express" lane, with the remainder of claims flowing through either a "special operations" lane (claims requiring special handling) or "core" lane. This segmented, case-management approach to claims processing is creating efficiencies within our workforce.

VBA's planned digital, paperless environment, VBMS, will be fully implemented in all regional offices by the end of the year. Once fully developed and implemented, VBMS is projected to provide a 20 percent increase in productivity, or an estimated increase in production by 238,000 additional claims in FY 2015.

VBA's partnership with Veterans Service Organizations (VSO) is also crucial to our transformation. Today, less than 5 percent of claims received by VA come with the documentation necessary for a decision. As a result, VBA reviewers commit countless hours attempting to locate medical and service records, and arranging physical examinations needed to support Veterans' claims. VBA is greatly expanding education and collaboration efforts with VSOs that result in the submission of more "fully developed" claims (FDC) (htto://benefits.va.qov/transformation/fastclaims/) — claims that come to VA ready for final review and decision.

To bring new efficiencies to the collection of medical information needed for claims decisions, VA developed Disability Benefits Questionnaires (DBQ). DBQs are templates that solicit the medical information necessary for VA to evaluate the level of disability for a particular medical condition. The release of these DBQs to the public allows Veterans to take them to their private physicians, facilitating submission of fully developed claims packages for expedited processing.
VBA is also completing the integration with other Federal departments that enables inter-departmental data review and exchange to support pension and disability claims processing. This includes Social Security Administration and Internal Revenue Service (income verification) and DoD (military personnel and medical records). Currently, claims take an average of 295 days to process, and approximately 239 of those days are taken up in the process of gathering information from other sources.

Question 3: National implementation of the Veterans Benefits Management System (VBMS), which will transition the VA from paper to electronic claims, is currently underway, in fact if I recall correctly, as of March 2013 it is currently in place at 25 regional offices. Are you still on track to have the VBMS in every regional office by the end of 2013?

Answer: As of April 26, 2013, VBMS was implemented at 42 regional offices and the Appeals Management Center. The remaining 14 regional offices will have VBMS in place by the end of 2013.

Question 4: What is the current percentage of claims that are filed on paper?

Answer: Currently, 97 percent of all claims are received and processed in paper. However, VA is rapidly deploying capabilities to encourage Veterans and their advocates to submit claims and supporting evidence electronically. This past quarter, VA deployed an online application and upload capability. Without any advertisement of this new functionality, VBA already received almost 5,000 claims electronically. With the full deployment of VBMS nationwide this year and help of VSOs, VA will be working aggressively to rapidly increase the percent of claims filed electronically. VBA's goal is to electronically receive 30 percent of all evidence and claims-related information by the end of FY 2014, and 70 percent by FY 2018.

Question 5: Mr. Secretary how many claims have been processed using the VBMS?

Answer: As of April 30, 142,947 claims are pending in VBMS, and 5,800 claims have been completed using VBMS in FY 2013.

Question 6: How long will it take for us to see tangible progress on reducing the backlog using the VBMS?

Answer: The VBMS pilot stations paved the way for the accelerated deployment of VBMS, which will enable VBA to track and measure productivity outcomes in a consistent and accurate manner once all regional offices are operating with the new technology and after a period of stabilization.

Question 7: In Secretary Shinseki's testimony, he stated that the average number of claimed conditions for recently separated Servicemembers which is now in the 12 to 16 range which is an increase in the number of disabilities claimed by Veterans of earlier eras. Do claims processors have to have all claimed conditions verified before a claim can be processed or as conditions are verified the claim for that condition is approved?

Answer: Before any condition can be granted service connection, the VA decision maker must have evidence of three things: an injury, disease, or event in service; a current diagnosis; and medical evidence of a nexus, or link, between the two. Provided the decision maker has evidence to support these three things, a decision can be rendered on that condition even if we lack the evidence needed for the additional claimed conditions. In 2010, VBA incorporated into our Adjudication Procedures Manual guidance directing claims processors to issue intermediate ratings when some, but not all, claimed conditions can be granted while we continue to gather evidence concerning other claimed conditions.

Question 8: The FY 2014 budget request includes $136 million for the Veterans Claims Intake Program (VCIP), which is a continuation of a scanning program that began scanning on September 10, 2012. I have a couple questions about this, first how many scanning contracts does the VA have for VCIP and second how many documents are scanned per month?

Answer: VA executed contracts on July 24, 2012, with two vendors to provide scanning (document conversion) services. These vendors upload the claims documents to VBMS, and as VBMS is nationally deployed, the pace of image uploads accelerates. Below is the number of images uploaded to VBMS per month in FY 2013:

October	0.2 million
November	1.7 million
December	5.2 million
January	8.4 million
February	16.6 million
March	21.0 million
Through April 21	22.9 million
Total	76.0 million

Question 9. Once a document is scanned how long does it take to get to completed package to a claims processor?

Answer: This process takes 48 hours or less.

Question 10: The VA Strategic Plan to Eliminate the Compensation Claims Backlog talks about teams working together on one of three segmented lanes: express, special operations, or core. In this plan it states that the VBA projects that segmented lanes can accelerate 350K "express" claims from 262 days to complete to 80 days, a reduction of 182 days, reducing average days to complete (for all claims) by 54 days. As of December 2012, 51 regional offices are currently using the segmented lanes structure, and the remaining 5 offices will be implementing the new model during the second quarter of FY 2013. Have we seen any results from this initiative because when looking at current claims processing data it doesn't appear to be working?

Answer: Segmented lanes allow Express claims (claims with 1-2 issues and those that are fully developed) to be processed expeditiously. Claims in the Express lane wait an average of 100 days less than Core or Special Operations claims, and Express lane RVSRs complete roughly three times the number of claims completed by Special Operations and Core lane RVSRs. Approximately 30 percent of the total inventory is now processed quicker and more efficiently through the Express lane. After 60 days in the organizational model, overall productivity per RVSR increased 17 percent, and overall station production increased three percent.

Question 11: The Department and the DoD were directed to develop an electronic health record system that would follow a service member from enlisted in the military to the time they exited. However, because of numerous problems you and Secretary Leon Panetta decided to alter the original goal of iEHR and focus on making your current EHR systems more interoperable.

Answer: The Department of Veterans Affairs (VA) is committed to delivering, with the Department of Defense (DoD), a single, joint, common, integrated Electronic Health Record (iEHR) that is open in architecture and non-proprietary in design. To accelerate delivery and meet the 2014 initial operating capability (IOC) deadline, the iEHR program has identified a set of "quick win" opportunities. The "quick win" accelerators are planned to enable an accelerated delivery schedule and increase interoperability between the departments while staying within the current budget. The four accelerators are as follows:

1. **Accelerate the Federation of VA and DoD Clinical Health Data through:**

- Correlation of VA data to DoD data using translation mechanisms such as the open Health Data Dictionary (HDD) or direct use of standard terminologies to enable full computable data interoperability in at least 7 clinical categories/domains (laboratory, pharmacy, problem list, allergies, immunizations, vitals, and note titles).
- Logically federate VA Veterans Health Information Systems and Architecture (VistA) data with DoD's Clinical Data Repository (CDR).
- Accessibility of real-time data between VA and DoD.
- Patient access to data via Blue Button (BB) in coordination with all VA and DoD partners that have a current role in development.
- Clinician access to federated data.

Deploy Janus to Seven Additional Sites: By July 31, 2013, deploy Janus Joint Legacy Viewer (JLV) to selected users at four additional VA Polytrauma Rehabilitation Centers (PRC) (Minneapolis, Tampa, Palo Alto, and Richmond), Alaska VA Health Care System (Anchorage), Joint Base Elmendorf-Richardson (JBER) Hospital, and Walter Reed National Military Medical Center (NMMC). In addition, expand the number of users at San Antonio VA Medical Center (VAMC) and San Antonio Military Medical Center (SAMMC).

Ensure Rapid Creation of the VA-DoD Medical Community of Interest (MEDCOI) network and security infrastructure. Implement MED-COI at IOC sites in November 2013.

Ensure Rapid Adoption of the Common DoD-VA Identity Management Solution to support iEHR FOC and data interoperability acceleration. VA has decided to retain the Master Veteran Index (MVI) Identity Management System for internal VA enterprise operations. VA will use the Defense Management Data Center services as the single authoritative source for identity for Servicemembers and families and the DoD Electronic Data Interchange Personal Identifier (EDI-PI) will be utilized as the iEHR joint identity. VA and DoD will determine business rules required to effectively integrate the two systems. In addition, VA has enhanced the Veteran Identification Card to include the EDI-PI directly on the card and in the barcode.

Question 12: Vista will be your core system, have you been given any indication of what core system the Department of Defense will choose?

Answer: VA has committed to deploying an iEHR core (as defined by the joint clinician working group) based on VistA. The Secretary of Defense is reviewing options for the DoD's core decision.

Question 13: With Secretary Hagel being familiar with Vista system, given his time at the Department of Veteran Affairs; Have you recommended the Vista system to the DoD?

Answer: VA formally responded to the DoD Request for Information (RFI) on replacing its legacy electronic health record system. In our response, VA provided DoD with information to support DoD's consideration of VistA as its core for the iEHR. A copy of VA's response to the RFI can be found at the following link:
http://www.osehra.com/content/final-white-paper-vista-core-ehr-system-dod-medics-rfiresponse

Question 14: What effect would having the same or an interoperable electronic health system have on the claim backlog?

Answer: The iEHR is a distinct issue from the claims backlog. Its purpose is to improve patient-centered care and provide beneficiaries access to a comprehensive medical profile that supports the transition of care between VA and DOD treatment

facilities. The iEHR will also benefit VA and DoD in areas outside of healthcare delivery; this includes the claims backlog.

Question 15: The FY 2014 budget request included $251 million for iEHR, can you explain what that money is for since you have altered the original goal of iEHR?

Answer: The goal of a single, joint, common iEHR that is open in architecture and non-proprietary in design is still the goal for both Departments. All funds obligated to date were obligated according to plan, and used to establish a foundation for both DoD and VA, irrespective of a decision on core systems. The focus of these efforts has remained on architecture, design, infrastructure, and initial clinical capabilities. The FY2014 VA budget request will be used to deliver on the goals to meet IOC and related scheduled deliveries and to deploy an iEHR core based on VistA.

Question 16: What was the rationale for ceasing the integrated electronic health record program after you and Secretary Panetta both told us in Congress that you were going to make this work? Where was the breakdown and why is it suddenly not possible? What is the fix going forward and is there any possibility of the Department of Defense using VISTA since it is the most widely used EHR in the US?

Answer: As explained above, VA is committed to delivering, with DoD, a single, joint, common iEHR that is open in architecture and non-proprietary in design. The two Departments have agreed to certain accelerators as described above to meet the 2014 initial operating capability (IOC) deadline.

Question 17: The backlog of claims has continued to increase over the last couple years and I realize the addition of Agent Orange is a large factor in that increase, but there doesn't seem to be any improvement in the process in fact it is getting worse. So what is the plan to fix it? And how are you evaluating your plan, because according to the GAO you are not on track to reach your stated goal of 125 days by 2015. In addition, it appears to me that there are some problems with the VBMS rollout? (ask for an update in writing before the hearing)

Answer: It is important to note that the VA Strategic Plan to Eliminate the Compensation Claims Backlog sent to Congress in January of 2013 indicates that the inventory of claims would continue to increase for the near term before declining.

VBA is aggressively implementing its Transformation Plan, a series of tightly integrated people, process, and technology initiatives designed to eliminate the claims backlog and achieve our goal of processing all claims within 125 days with 98 percent accuracy in 2015. VBA is retraining, reorganizing, streamlining business processes, and building and implementing technology solutions based on the newly redesigned processes in order to improve benefits delivery.

VBA is tracking execution of its Transformation Plan against its key measures of performance that are tracked daily, weekly, monthly, and on a fiscal-year basis. VBA's Implementation Center, established at VBA's Central Office in Washington D.C., utilizes a comprehensive change management approach to oversee initiative deployment and

execution. The focus is on implementing initiatives that achieve the greatest gains, without degrading current performance.

National deployment of VBMS is underway, with 42 offices using VBMS as of the end of April 2013. Deployment to all 56 regional offices will be completed by the end of the year.

Question 18: How are you addressing these claims backlogs with new veterans from Iraq and Afghanistan who on average are waiting even two months longer with some in excess of 600 days? Have you, Secretary Shinseki, spoken directly with the Iraq and Afghanistan Veterans Association about how you're addressing these issues?

Answer: By refocusing resources that were previously directed at Agent Orange claims, VBA has made reductions in the backlog of claims from separating Servicemembers a priority. Benefits Delivery at Discharge (BDD) and Quick Start are programs focused on providing benefits to Servicemembers who are approaching discharge. Since July 2012, average processing time for Quick Start claims has decreased by 68 days, from 337 days to 269 days. Similarly, the average number of days pending has decreased since May 2012 for both Quick Start claims (55 days) and BDD (12 days). As of April 20, the average processing time for BDD claims is 260 days. VBA will continue to prioritize and expedite claims for our wounded warriors returning from Iraq and Afghanistan.

VBA works closely with VSOs and other stakeholders and provides information about how to assist Veterans in accessing and applying for benefits. VBA attends VSO and service-partner conferences and training meetings to provide information on how to assist Veterans in submitting electronic claims. In addition, newly discharged Veterans receive Welcome Home packages 6, 12, and 24 months after discharge. Service- partners are invited to the VSO quarterly forum with all VBA business lines and the service partner quarterly meetings with the Under Secretary for Benefits. Through eBenefits, newly discharged Servicemembers can receive e-mails about benefits and services and how to access them.

VA and DoD have joined together to create an integrated Disability Evaluation System for Servicemembers who are being medically retired or separated. The iDES provides a single set of disability examinations and a single-source disability rating, for use by both Departments in executing their respective responsibilities. This results in more consistent evaluations, faster decisions, and timely benefits delivery for those medically retired or separated. As a result, VA can deliver benefits in the shortest period allowed by law following discharge, thus reducing the "benefit gap" that previously existed under the legacy process, i.e., the lag time between a Servicemember separating from DoD due to disability and receiving his or her first VA disability payment. The DoDNA integrated approach has also eliminated many of the sequential and duplicative processes found in the previous legacy system.

Question 19: I'm very worried about the number of mental health providers in the VA and specifically getting veterans in to see these providers in a timely manner. How can VA recruit more qualified mental health staff?

Answer: VA is committed to increasing access to all services VA offers, including providing increased access to mental health care. VHA enjoys one of the best employer brands in the health care field as an employer of choice, as well as serving a noble mission. VHA recruitment and marketing is strong and we continue to enhance it to recruit high quality medical providers. VHA is on track to meet the President's August 31, 2012, Executive Order increasing the number of our Mental Health Providers by 1,600 by June 30, 2013. This increase has been achieved by deploying specific geographic and occupationally targeted advertisement and recruitment efforts nationwide.

Throughout our vigorous Mental Health Hiring Initiative, VHA has collected lessons learned about ways to improve methods to move applicants through the hiring pipeline more expeditiously. Additionally, VHA has offered national-level resources to field Human Resource Offices around the country to provide additional resources to help facilitate timely hiring and onboarding of these much needed professionals. VHA will continue to look at ways to facilitate the efficiencies of the hiring process without sacrificing the important need of thoroughly vetting and placing qualified professionals to serve our Nation's Veterans.

Question 20: How can we ensure that mental health patients are seen more regularly to address some of these issues causing such an alarming suicide rate instead of every two or three months?

Answer: VHA has a number of systems to recognize those who are at increased risk for suicide. These include screening for mental health conditions in primary care and follow-up evaluations of the risk for suicide in those who screen positive, ongoing monitoring of all patients receiving mental health services to support the identification of those who are at risk, and specific training for all staff having contact with patients about how to recognize warning signs of suicide. There are also intensive ongoing campaigns to encourage Veterans (and their families or friends) to contact the Veterans Crisis Line at 800-273-TALK when they are concerned about increased risks. Additionally, VA has multiple points of entry including emergency departments and urgent care settings that are available for in-person walk-in evaluation for Veterans at risk of suicide.

When anyone with an increased risk for suicide is identified, they are evaluated and their treatment plan is reviewed and revised as appropriate. Those at the highest risk may be hospitalized to ensure that they can receive intensive evaluations and treatment in a safe environment. Others at high risk receive intensified services until they stabilize, including the development of safety plans, increased contacts with providers including the requirement for a minimum weekly contact the first month after the risk is identified, and mandated outreach follow-up for appointments missed by the patient. VHA evaluates its suicide prevention program in an ongoing way, and continually adds to it.

Question 21: What bureaucratic steps can be changed or eliminated to help get the medical records faster from federal agencies (SSA, National Guard, reserves) when requested in regards to a VA claim?

Answer: VBA is currently working with other Federal agencies that hold vital Federal records needed to process Veterans disability claims. VBA is partnering with Social Security Administration (SSA), National Guard Bureau, and Reserve Affairs (RA) to discuss and identify policy and procedural changes that would increase the efficiency of records transfer. Currently, we are focused on implementing the transfer of Federal records between agencies in an electronic format. This is seen as a major step toward getting the needed records more quickly.

VBA has an agreement with DoD to provide 100-percent-complete service treatment and personnel records in an electronic, searchable format for the 300,000 Active Duty, National Guard, and Reserve Servicemembers departing annually. This will increase the number of Fully Developed Claims submitted. When fully implemented, this action has potential to cut as much as 60-90 days from the "awaiting evidence" portion of claims processing.

In February 2013, VA developed an expanded data-sharing initiative with the Internal Revenue Service and SSA for up-front verification of income for pension applicants and to streamline income verification matches. This initiative enabled VBA to eliminate an annual reporting surge of 150,000 work items and redirect significant FTE to address the backlog of Dependency and Indemnity Compensation claims from Survivors.

Question 22: How can you get Vet Centers into rural areas?

Answer: The placement of Readjustment Counseling Service's (RCS) "brick and mortar" Vet Centers are determined using two fundamental criteria: Veteran population and proximity to the next closest Vet Center. Each Vet Center is assigned a Veteran Service Area (VSA), composed of surrounding counties in which Vet Center staff are responsible for providing readjustment counseling and related services. Every county in the United States is accounted for within the Vet Center VSAs. Vet Center staff routinely travel within the Vet Center's VSA to provide outreach and direct services through community access points. Community access points are located in areas where there is a demand for services and are usually operated in community space. Vet Center staff regularly review the needs of the local Veteran population and adjust these access points accordingly.

RCS also operates a fleet of 70 Mobile Vet Centers (MVCs), located throughout the continental United States, Hawaii, and Puerto Rico. One of the primary MVC missions is to provide access to services and outreach to Veterans and their families who are geographically distant from existing services. MVCs regularly participate in events in rural communities.

Finally, RCS operates the Vet Center Combat Call Center 877-WAR-VETS, which is a confidential around-the-clock call center where combat Veterans and their families can call anytime to talk about their military experience and transition home. Combat

Veterans from several eras and family members of combat Veterans staff the Call Center. The Call Center has warm handoff capability with every Vet Center, the VA National Crisis Hotline, the VA Primary Care Triage Hotline, and the National Caregiver's Hotline.

Question 23: My district office constantly gets complaints about the 800 number call center, from long waits, wrong info, being hung up on, leaving messages with no return calls, and not being able to talk to someone in their regional office or state. How do we improve the quality of service in these call centers?

Answer: VA has made significant progress in improving the Call Center experience that our Veterans receive, but we recognize that further improvements are needed. The VBA Call Center is experiencing heavy call volumes. These heavy volumes are directly correlated to the rising inventory of pending claims. While VBA processed over a million claims each of the past three fiscal years, the number of pending claims remains high, causing an increase in call volume primarily to check the status of claims.

Although wait times for calls are extended, the quality of calls is high. VBA utilizes the JD Power Voice of the Veteran survey to measure client satisfaction. VBA achieved a national index score of 774 for March 2013. The JD Power Service Industry benchmark is 801, and we are trending to that score. In addition, monthly quality call reviews are conducted for each agent to ensure technically accurate information is provided to callers.

We apologize for the delay Veterans experienced during peak periods. VA's Virtual Hold provides callers with choice and flexibility. The caller can choose to hold for an agent or leave their name and phone number for VBA return his or her call. Callers do not need to wait on hold if they choose the Virtual Hold call back feature. VBA currently has a 93 percent successful re-connect rate, and the system has returned over 7.2 million calls since September 2011. There may be pockets of time during peak volume periods when the Virtual Hold call back functionality may not be provided.

There are a number of initiatives underway to enhance the service experience. A key initiative is the expansion of online self-service capability via eBenefits. An eBenefits account is free and allows Veterans to access their personal benefit information 24 hours a day, seven days a week. The eBenefits portal provides over 45 self-service features, including features to: check the status of a claim or appeal; review the history of VA payments; request and download military personnel records; and secure a certificate of eligibility for a VA home loan. Enrollment in the eBenefits portal is now mandatory upon entry into military service.

VBA fully deployed the Unified Desktop on December 22, 2012, to more than 7,000 call center personnel in the National Call Centers and Pension Call Center. The Unified Desktop provides a single, unified view of VA clients' military, demographic, and contact information; benefits eligibility; and claims status through one integrated application vs. using 13 different applications previously.

Question 24: My greatest fear for our Veterans is that as the war draws down the "sea of goodwill" towards the Veterans and military community that former Chairman of the Joint Chiefs, Admiral Mullen previously talked about starts drying up and we haven't fixed some these issues at the VA and it then just gets harder and harder when the issue is not on the public's mind. It seems to me this administration needs a comprehensive National Veterans Strategy across several federal agencies to address the issues of backlog claims, mental health access, suicides, homelessness, employment and so on with our veterans. How can we push for a comprehensive plan to address these issues?

Answer: The Department of Veterans Affairs (VA) recognizes the importance of public support in addressing the needs of the Nation's Veterans and the administration continues to affirm this position especially in the areas of the claims backlog, mental health, homelessness, veterans employment, and access. To that end, VA has begun making provisional decisions on the oldest claims in the inventory, mandated overtime for claims processors and prioritizes claims for homeless Veterans and those claiming financial hardship, the terminally ill, former Prisoners of War, Medal of Honor recipients, and Veterans filing fully developed claims. VA has partnered with the Disabled American Veterans (DAV) and the American Legion to create the Fully Developed Claims (FDC) Community of Practice. VA, in partnership with HUD, has reduced the Veteran homeless population from an estimated 76,000 in 2009 to approximately 67,500 by the latest count in 2011, an 11 percent improvement. VA has continued collaboration efforts with the Department of Defense (DoD) on a variety of programs to ensure a seamless transition from Servicemember to Veteran status, including the Integrated Disability Evaluation System (IDES) process, implementation of transition assistance provisions in the Veterans Opportunity to Work (VOW) to Hire Heroes Act of 2011 and expanding access to quality mental health services as called for in President Obama's August 31, 2012 Executive Order to Improve Access to Mental Health Services for Veterans, Service Members, and their families. Access through the eBenefits portal has provided Veterans with more than 50 self-service features to manage and view benefit and service offerings online. As of March 31, 2013, there were 2,606,173 individuals with access to eBenefits, up from just 250,000 in 2009. VA uses a multi-pronged approach to improve Veteran employment opportunities, and recent initiatives to ensure employment success for Veterans. The Veterans Retraining Assistance Program (VRAP), as of April 2013, issued 96,000 Certificates of Eligibility. Vocational rehabilitation benefits for Veterans who previously exhausted unemployment benefits were extended, and tax incentives for private enterprises hiring Veterans were also provided.

Question 25: How is the VA working to achieve 100% compliance with the CDC's new recommendation that all Baby Boomers be tested for hepatitis C?

Answer: VHA currently recommends testing those at risk including, but not limited to Veterans who served in the Vietnam era (dates of service 1964-1975). As of the end of calendar year 2011, VHA has tested approximately 65 percent of Veterans in VHA care who were born between 1945-1965 (Baby Boomers) for hepatitis C. In contrast, in the general U.S. population, birth cohort testing has been limited, and the U.S. Centers for Disease Control and Prevention (CDC) estimates that only 25 percent of chronically infected individuals have been tested and know their diagnosis. VHA is planning the following steps regarding birth cohort testing:

1. Re-examination of current VHA policy in light of current recommendations by the CDC, the U.S. Preventive Services Task Force, and other advisory groups.

2. Based on this re-examination, the following measures by VHA's National Viral Hepatitis Program in the Office of Public Health (OPH), and VHA's National Center for Health Promotion and Disease Prevention are being considered:

a. Revision of VHA's Preventive Services Guidance Statement on testing for hepatitis C virus (HCV).
b. Additional training for VHA providers, especially in primary care, regarding hepatitis C testing and treatment.
c. Creation of print and Web-based materials to educate patients and providers in VHA about HCV testing.
d. Use of social marketing campaigns aimed at both providers and patients to increase awareness of hepatitis C.
e. Analysis of facility-level testing data to identify best practices and areas for improvement.
f. Use of telehealth and teleconsultation platforms to train providers, particularly those at Community-Based Outpatient Clinics, about hepatitis C testing.

Question 26: From 2001-2008, one-fifth of veterans with HCV had received antiviral therapy. How many veterans have received antiviral treatment for HCV in each of the last four years?

Answer: The most recent data available are as follows. Note that the population in care in any given calendar year is not exactly the same as in other years, e.g., those patients in care in 2012 may not have been in care in 2011 or other years, and vice- versa.

Calendar year	Number of HCV+ Veterans in VHA care	Number in treatment	Number ever treated
2012	173,416	6,405	38,860
2011	170,119	4,586	36,898
2010	165,005	5,376	35,841
2009	156,725	6,021	33,981

Question 27: Given the convergence of an aging population, rapid disease progression, and increasing incidence of cirrhosis in the veterans population, what steps is the VA taking to ensure that veterans served by the VHA have access to new therapies expected to enter the market in the coming 12 — 24 months that may be more tolerable and offer higher cure-rates than with a potentially shorter duration of treatment?

Answer: VHA has moved aggressively to make new treatments for hepatitis C available to affected Veterans in care:

- Within a week after FDA approval of the first direct acting antivirals (DAAs) active against HCV, VHA's Pharmacy Benefits Management Services (PBM) had drafted detailed instructions for use of these agents as part of a 3-drug regimen referred to as "triple therapy."
- Veterans were offered triple therapy with these new agents within a few weeks of approval, prior to addition to the VA National Formulary (VANF).
- Within 10 weeks of FDA approval, one agent had been added to the VANF, with the other readily and officially available as a nonformulary agent.
- At the same time that these agents were added to the VANF or made officially available, VA's Office of Public Health (OPH) sponsored a large (300-provider) training to educate VA providers on safe and effective use of these new drugs.
- PBM has conducted separate trainings, with participation of OPH staff, for clinical pharmacists on use of these new drugs.
- OPH produced educational materials to educate patients and providers on the new drugs.
- On August 26, 2011, VHA's Deputy Under Secretary of Health for Operations and Management issued a memorandum to Veterans Integrated Service Network (VISN) Directors establishing a policy that permits all new drugs to be considered as treatment options when they are clinically indicated, regardless of drug cost.
- To allow for appropriate resource planning, VISN and Facility Directors received detailed projections prepared by PBM and OPH showing the number of Veterans with HCV who were potential candidates for treatment with triple therapy. This allowed VISN-wide initiatives to allocate resources so as to maximize access to therapy.
- In collaboration with OPH, PBM trained hundreds of new providers to treat HCV.
- In collaboration with OPH, VHA's Office of Specialty Care Services has begun using a novel teleconsultation model to train providers at Community-Based Outpatient Clinics (CBOC) to deliver HCV care.

With regard to newer drugs that may be safer and more effective than current therapies, and which are expected to receive FDA approval over the next 12-24 months, VHA is planning the following steps:

- Detailed projections of the numbers of Veterans (both untreated and those who have failed previous treatment) who may benefit from these new drugs.
- Collaboration with PBM on the development of detailed instructions for use in anticipation of FDA approval, to facilitate rapid consideration of such drugs.
- After FDA approval, conduct new training initiatives to educate VA providers.
- Production of print and Web-based educational materials for patients and providers.
- Continued training of new HCV providers.
- Continued use of teleconsultation to expand access to patients seen at CBOCs.
- Collection of data on utilization and treatment outcomes.

[Questions for the Record submitted by Congressman Price for the Honorable Eric K. Shinseki follows:]

Question 1: Although the Department of Veterans Affairs has made some progress in its stated goal to reduce and, ultimately, eliminate the burgeoning disability claims backlog, the delay experienced by hundreds of thousands of men and women who served and sacrifice for our country is simply unacceptable. While initiatives such as the Veterans Benefits Management System and Veterans Claims Intake Program— along with joint-Departments of Defense and Veterans Affairs ventures designed to ease the transition back to civilian life after a period of service—are on track to provide some relief, it is clear that more must be done. I believe that Congress has a responsibility to not only repair an overburdened system, but to be accountable to our veterans by providing a comprehensive, accurate explanation of what is being done to address the problem in a timely manner. I respectfully submit the following specific questions for the record:

a) I understand the VA plans to roll out VBMS nationwide by the end of 2013. Does the Department have the resources it needs to achieve this goal? If not, what additional resources (financial, technological, or otherwise) are necessary for the Department to achieve this goal?

Answer: Yes, VA has the resources needed to achieve this goal.

b) If a contract for the development of VBMS software was awarded uniquely to a private company or other non-governmental entity, by what process was this contract awarded?

Answer: VBMS development is primarily supported by the Space and Naval Warfare System Center Atlantic (SPAWAR). SPAWAR is supporting VA in VBMS development in the areas of Engineering, AGILE Development, operations, help desk, Program Management Office support, and testing. In addition to SPAWAR, the acquisition strategy for VBMS also includes other interagency partners and VA contractors to develop and integrate multiple components included in this system of systems.

c) Although VBMS is intended to facilitate timely processing of future disability benefit claims, I understand there remains a substantial backlog of existing paper disability claim materials—many of which are stored in my state of North Carolina. Does the Department currently possess the resources (financial, personnel, or otherwise) and capability necessary to quickly and securely process these remaining records into an electronic benefits management system such as VBMS? If not, what additional resources does the Department require in order to quickly and securely process these remaining records?

Answer: For the current fiscal year, VA has the funding to quickly and securely convert paper disability claim material into VBMS for all newly received claims. This funding is included in VA's budget requests for FY 2014 as well.

VA is focusing on the conversion of materials related to active claims and is carefully examining the cost and benefits of converting other historical records. The records for Veterans not filing claims will be converted to VBMS or retired to Federal Archives based on a variety of factors including the cost to convert or store, the operational capacity of VA's scan vendors, and other factors.

Fiscal year to date, VBA has completed approximately 4,600 claims from start to finish in VBMS. However, the current inventory of nearly 800,000 paper-based claims are in various stages of development, and will therefore continue to be processed in paper. VBA will have approximately 30 percent of its total claims inventory in VBMS by the end of 2013.

d) Once the Department achieves its stated goal of eliminating the claims backlog and achieving a disability benefit claims processing turnaround of 125 days or less, how will the Department ensure that a backlog will not develop in the future?

Answer: VA's goal of processing claims within 125 days or less with 98 percent accuracy is a permanent goal. Our transformation plan, which incorporates people, process, and technology initiatives, will ensure that the backlog is resolved and that the results are sustained and continuously improved upon.